







# MEDICAL & ACTIVITY CONSENT FORM

CAMP WHEEZEAWAY, May 26-31, 2019

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Nick Name

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Mother Home Mother Work Mother Cell  
( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Father Home Father Work Father Cell

We will call the above numbers first in case of an emergency. If there is no answer, we will call alternate numbers below:

Name Relationship Phone# Alternate Phone #

Name Relationship Phone# Alternate Phone #

It is understood that in order to attend Camp WheezeAway, the child named above is covered by the private insurance or Alabama Medicaid policies. In consideration of the services which are rendered to the child named above, pursuant hereto, the following is a listing of any insurance policies we have in force on named child. YMCA Camp Chandler/ Camp WheezeAway and its agents have my permission to present this information to proper medical personnel should any medical emergency care be necessary. It is understood that this authorization shall be effective Sunday, May 26-31, 2019.

Insurance Company/Medicaid/All Kids Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

I have attached a copy of all insurance cards:  Yes

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Agreement: I understand that my child must observe the same camp rules as other children and has my permission to participate in all camp activities. I hereby give consent for the administration of medications that are deemed necessary so treatment of an emergency nature may be given to my child by the physician or physicians in charge if I cannot be contacted within what they consider a reasonable time.

I understand that photographs and video pictures will be taken of my child for the purposes of recording the camp experience. These photographs or video pictures may be used for publicity about the camp and fundraising activities.

**Neither the camp nor the Medical Staff assumes any other responsibilities.**

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

The following people are authorized to PICK UP MY CHILD FROM CAMP WHEEZEAWAY ON FRIDAY, MAY 31 BY 11 AM

\_\_\_\_\_

For Use by Camp WheezeAway Staff Only

|                      |             |             |
|----------------------|-------------|-------------|
| Signed out by: _____ | Date: _____ | Time: _____ |
|----------------------|-------------|-------------|



# MEDICAL HISTORY/INFORMATION: Parent Form (Page 1)

Child's Name: \_\_\_\_\_  
Last First Nick Name

## ASTHMA HISTORY

How many years has your child had asthma? \_\_\_\_\_  
How frequently does your child wheeze?  Daily  Weekly  Other, explain: \_\_\_\_\_  
How frequently does your child cough?  Daily  Weekly  Nightly Other: \_\_\_\_\_  
How many times a year does your child catch a cold? \_\_\_\_\_  
Is there a difference in your child's asthma in April/May (spring) compared to July/August (summer)?  Yes  No  Not Sure  
If Yes, are his/her symptoms better or worse in April/May?  Better  Worse  Not Sure Please explain: \_\_\_\_\_

How many times in the **past 12 months** has your child left early from school because of an asthma related problem? \_\_\_\_\_  
In the past year, how many days of school was your child absent the entire day because of asthma? \_\_\_\_\_

How many times in the **past 12 months** has your child been seen as a walk in or an urgent visit by his/her regular doctor/clinic for an asthma related problem? \_\_\_\_\_  
How many times has your child been in the emergency room because of an **uncontrolled asthma attack**? \_\_\_\_\_  
Has your child been given corticosteroid medications (such as Prednisone, Prelone, Pediapred) for asthma?  Yes  No  
Date of most recent prescription for corticosteroid taken? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Has your child ever been hospitalized for asthma?  Yes  No Date of most recent hospitalization: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Has your child ever has been in Intensive Care Unit (ICU)?  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Has your child ever been placed on a respirator/ventilator for asthma?  Yes  No

Date of most recent visit to your child's asthma doctor or regular doctor: \_\_\_\_/\_\_\_\_/\_\_\_\_ Doctor: \_\_\_\_\_

**IMMUNIZATION HISTORY:** Date of last tetanus Immunization: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Has your child had chickenpox, or chickenpox vaccine?  Yes  No

## MEDICATION HISTORY: List all medications your child uses.

Include **All** Medications for Asthma & any Other Medical Problems (whether used regularly or sometimes)

| MEDICATION NAME: | Dosage (Amount) | Frequency (How Often) |
|------------------|-----------------|-----------------------|
| 1.               |                 |                       |
| 2.               |                 |                       |
| 3.               |                 |                       |
| 4.               |                 |                       |
| 5.               |                 |                       |
| 6.               |                 |                       |
| 7.               |                 |                       |

Is your child allergic to any medicines?  Yes  No

If Yes, Please list: Medicine: Reaction:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# MEDICAL HISTORY/INFORMATION: Parent Form (Page 2)

**OTHER MEDICAL HISTORY:** Please list any other medical conditions that your child may have:

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**ALLERGY HISTORY:**

**If your child is currently on allergy injections, these injections cannot be given at Camp WheezeAway. You MUST make arrangements with your physician concerning this matter.**

Does your child have significant **Respiratory Allergies?**  Yes  No

If Yes, check all that apply:  Dust  Mold  Dogs  Cats  Feathers  Pollens  
 Other, Please List: \_\_\_\_\_

Does your child have significant **food** allergies?  Yes  No

If Yes, Please list foods that should be avoided: \_\_\_\_\_  
\_\_\_\_\_

Is your child allergic to any **insect stings?**  Yes  No

If Yes, Please describe insect, the reaction, and current treatment:  
\_\_\_\_\_

**PERSONAL ADJUSTMENT**

Has your child stayed away from home overnight before?  Yes  No

Does your child bed wet?  Yes  No

Does your child have nightmares?  Yes  No

Does your child have any emotional or psychological concerns?  Yes  No

If Yes, Please describe: \_\_\_\_\_

**Any additional information/Comments you would like to include:** \_\_\_\_\_

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## Camp WheezeAway STATISTICAL/DEMOGRAPHIC Information

This information is used to attain grants for camp.

Number of siblings (brothers/sisters) in household: \_\_\_\_\_ Number of parents with asthma: \_\_\_\_\_

Does anyone living in the house smoke:  Yes  No

If Yes, who and how often: \_\_\_\_\_

### Race

- White  
 African-American  
 Hispanic  
 Other

### Total family yearly income:

- Under \$15,000  
 \$15,000 - \$29,000  
 \$30,000 - \$50,000  
 Over \$50,000

Mother's/Female Guardian level of education:

- Elementary School  
 High School (but did not graduate)  
 Completed High School or GED  
 Completed Trade/Vocational School  
 College education (but did not graduate)  
 Complete College (B.A. or B.S.)  
 Graduate level/professional degree

Father's/Male Guardian level of education:

- Elementary School  
 High School (but did not graduate)  
 Completed High School or GED  
 Completed Trade/Vocational School  
 College education (but did not graduate)  
 Complete College (B.A. or B.S.)  
 Graduate level/professional degree

All scholarships for Camp WheezeAway are provided by donations from individuals, grants, businesses and sponsorships. Without help from concerned breathers like you this program could not continue.

If you would like to make a donation to the YMCA Camp Chandler / Camp WheezeAway or know someone who would **sponsor a child**, please indicate below and we will forward information about our camp to them. The YMCA Camp Chandler is a non-profit, tax-deductible, 501(C)(3) Organization.

Make check payable to:

**YMCA Camp Chandler**

**Earmarked for Camp WheezeAway**



# FORM (Page 1)

**\*\* TO BE COMPLETED BY PHYSICIAN \*\***

**DEADLINE FOR RETURN OF ALL FORMS IS: MAY 1, 2019**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Nick Name

Asthma/Allergy Physician or  Primary Care Physician:

Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**\*\* CHILD MUST HAVE SEEN PHYSICIAN IN THE LAST (6) MONTHS \*\***

Latest Physical Exam: Date: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Any abnormal findings:  Yes  No If Yes, Please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does Child have any drug allergies?  Yes  No

If Yes, please list: \_\_\_\_\_

Any other allergies?  Yes  No

If Yes, please list: \_\_\_\_\_

Any hospitalizations in the past year for asthma?  Yes  No

If Yes, how many? \_\_\_ When? \_\_\_\_\_

Any oral or IV steroids required in the past year?  Yes  No # of times prescribed in past year: \_\_\_\_\_

Most recent date given: \_\_\_/\_\_\_/\_\_\_ Dose given: \_\_\_\_\_

Has child ever been on ventilator?  Yes  No When? \_\_\_\_\_

Admitted to an ICU?  Yes  No If Yes, how many times? \_\_\_\_\_ When? \_\_\_\_\_

Additional information: \_\_\_\_\_

Last Pulmonary Function Results: Date: \_\_\_\_\_

|            | Predicted | Measured | % Predicted |   |
|------------|-----------|----------|-------------|---|
| FVC        |           |          |             | Does child use Peak Flow Meter?<br>Predicted:<br>Personal Best: |
| FEV1       |           |          |             |   |
| FEF 25-75% |           |          |             |   |
| Peak Flow  |           |          |             |   |



## Physician Form (Page 2)

Please list below all medication currently prescribed:

| Medication   | Dose | Frequency of Use | Medication | Dose | Frequency of Use |
|--------------|------|------------------|------------|------|------------------|
| ASTHMA MEDS: |      |                  | SKIN:      |      |                  |
|              |      |                  |            |      |                  |
|              |      |                  |            |      |                  |
|              |      |                  | OTHER:     |      |                  |
| NASAL/SINUS: |      |                  |            |      |                  |
|              |      |                  |            |      |                  |
|              |      |                  |            |      |                  |
|              |      |                  |            |      |                  |

**Note: If child is currently on allergy injections, these injections cannot be given at Camp WheezeAway. Please make necessary arrangements.**

Does child have any problems with the following? If so, please explain

- Nasal/Sinus: \_\_\_\_\_
- Skin Problems: \_\_\_\_\_
- Convulsions: \_\_\_\_\_
- Heart Disease: \_\_\_\_\_
- Diabetes: \_\_\_\_\_
- Hearing Problems: \_\_\_\_\_
- Prosthesis: \_\_\_\_\_

List any other significant medical or psychological problems: \_\_\_\_\_

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Nurse Contact: \_\_\_\_\_

Are you interested in volunteering for Camp WheezeAway?    Yes    No

Would you be available for check in & registration on Sunday, May 26, 2019, 12 noon to 4PM?    Yes    No

Would you be available during the week of Camp May 26-31, 2019?    Yes    No  
 If yes, please call Amy CaJacob, MD 205-234-4315

Would you be willing to promote Camp WheezeAway to your contacts for financial support?    Yes    No

Physician's Comments: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Please fax completed Physician Forms To: Camp WheezeAway  
 C/O YMCA Camp Chandler  
 Fax: (334) 649-7516**





# YMCA CAMP CHANDLER

## Camp WheezeAway

### Parent to Counselor Letter

All information below will be shared with your child’s counselor, but will remain confidential from all other campers. Your cooperation in providing complete information on this form will help us to more effectively meet the needs of your child.

Camper’s Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female  
Nickname \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Grade (in coming Fall): \_\_\_\_\_ Session(s) your child is attending: \_\_\_\_\_

Has your child been away from home overnight before? \_\_\_\_\_

Has your child been to camp before?  Yes  No

Has your child been to Camp Chandler before?  Yes  No If yes, how many years? \_\_\_\_\_

How does your child feel about coming to camp? \_\_\_\_\_

What would you like your child to gain from his or her camp experience? \_\_\_\_\_  
\_\_\_\_\_

What chores does your child do at home? \_\_\_\_\_

What does your child do in his or her free time? \_\_\_\_\_

Can your child swim?  Yes  No

Is your child afraid of the dark?  Yes  No

Does your child sleepwalk?  Yes  No

Does your child ever wet the bed?  Yes  No

If yes, what are your suggestions to help avoid the bedwetting? \_\_\_\_\_

Does your child have any fears or concerns we should be aware of? \_\_\_\_\_

If so, how can we help him/her to have a good experience? \_\_\_\_\_

Does your child have any special dietary needs? \_\_\_\_\_

Things my child is allergic to: \_\_\_\_\_

Are there any special concerns that you would like our staff to be aware of? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian’s Signature: \_\_\_\_\_



**CHANDLER**

**Camp WheezeAway  
Camper to Counselor Letter\***

\*to be  
completed by  
camper

Are you ready for camp? We are, and we would like to get to know you a little better before you get here! Take just a few minutes and fill out this letter; it will help us to plan many activities for you and your cabin mates. Get ready, this summer will be an experience that will last a lifetime! We are going to have the time of our lives!

My name is \_\_\_\_\_, but my friends call me \_\_\_\_\_.

Some things that I really enjoy doing are \_\_\_\_\_

\_\_\_\_\_

My favorite subject at school is \_\_\_\_\_

Most of my friends say that I am \_\_\_\_\_

If you were to ask my best friend about me, they would say that I \_\_\_\_\_

My best friends are people who \_\_\_\_\_

I am coming to Camp Chandler because \_\_\_\_\_

I think my favorite camp activity will be \_\_\_\_\_

I think it would be fun if my cabin could do \_\_\_\_\_ as a camp activity.

As my counselor, I would like you to know \_\_\_\_\_

\_\_\_\_\_

One thing I really want to accomplish while I am at camp is \_\_\_\_\_

\_\_\_\_\_

I understand that I am coming to YMCA Camp Chandler to develop new skills, be a good friend, and have a great time. I understand that there are camp rules that I must follow in order for everyone to have fun. I agree to follow the YMCA Camp Chandler rules including being considerate of my cabin mates, cooperating with my counselors, and practicing good health habits.

Signed \_\_\_\_\_

## Montgomery YMCA Staff Code of Conduct

1. In order to protect YMCA staff, volunteers and program participants, at no time during a YMCA program may a staff person be alone with a single child where they cannot be observed by others. As staff supervise children they should space themselves in such a way that other staff can see them.
2. Staff shall never leave a child unsupervised.
3. Restroom supervision: Staff will make sure the restroom is not occupied by suspicious or unknown individuals before allowing children to use the facilities. Staff will stand in the doorway of the restroom while children are using the restroom. This policy allows privacy for the children and protection for the staff (not being alone with a child). If staff are assisting younger children, doors to the facility must remain open. No child, regardless of age, should ever enter a bathroom alone on a field trip. Always send children in pairs, and whenever possible, with staff.
4. Staff should conduct or supervise private activities in pairs—diapering, putting on bathing suits, taking showers, etc. When this is not feasible, staff should be positioned so that they are visible to others.
5. Staff shall not abuse any YMCA participant, child, volunteer or staff member including: physical abuse (to strike, spank shake, or slap); verbal abuse (to humiliate, degrade, or threaten); sexual abuse (to inappropriately touch or speak); mental abuse (to shame, withhold kindness, or be cruel); neglect (to withhold food, water, basic care, etc.). Any type of abuse will not be tolerated and may be cause for immediate dismissal.
6. Staff must use positive techniques of guidance, including redirection, positive reinforcement, and encouragement rather than competition, comparison and criticism. Staff will have age-appropriate expectations and set up guidelines and environments that minimize the need for discipline. Physical restraint is used only in pre-determined situations (necessary to protect the child or other children from harm), is only administered in a prescribed manner, and must be documented in writing.
7. Staff will observe and report to immediate supervisor any fever, bumps, bruises, burns, etc. Questions or comments will be addressed to the parent or child in a non-threatening way. Any questionable marks or responses will be documented. **ALL REPORTS ARE TO BE CONFIDENTIAL.**
8. Staff will respond to children with respect and consideration and treat all children equally regardless of sex, race, religion or culture.
9. Staff will respect children's rights to not be touched in ways that make them feel uncomfortable, and their right to say no. Other than diapering, children are not to be touched on areas of their bodies that would be covered by a bathing suit.
10. Staff will refrain from intimate displays of affection towards others in the presence of children, parents and staff.
11. While the YMCA does not discriminate against an individual's lifestyle, it does require that in the performance of their job, they will abide by the standards of conduct set forth by the YMCA.
12. Staff must appear clean, neat and appropriately attired.
13. Using, possessing or being under the influence of alcohol or illegal drugs during working hours is prohibited. Using illegal drugs at any time is prohibited.
14. Smoking or use of tobacco in the presence of children or parents on YMCA property or while participating in a YMCA program is prohibited.
15. Profanity, inappropriate jokes, sharing intimate details of one's personal life, and any kind of harassment in the presence of children, parents, or any other staff is prohibited.
16. Staff must be free of physical and psychological conditions that might adversely affect the children's physical or mental health. If in doubt, an expert should be consulted.
17. Staff will portray a positive role model for youth by maintaining an attitude of respect, loyalty, patience, courtesy, tact and maturity.
18. Staff may not be alone with children they meet in YMCA programs outside of the YMCA. This includes babysitting, sleep overs, and inviting children to your home. Any exceptions require a written explanation before the fact and are subject to administrator approval.
19. Staff are not to transport children in their own vehicles.
20. Under no circumstances should staff release children to anyone other than the authorized parent, guardian, or other adult authorized by the parent or guardian (written parent authorization on file with the YMCA).
21. Staff are required to read and sign all policies related to identifying, documenting, and reporting child abuse and attend training on the subject as instructed by a supervisor.
22. Staff will act in a caring, honest, respectful, and responsible manner.
23. Any and all infractions and violations of this policy should be reported to the Branch Director or the General Director.

I understand that it is my responsibility as a parent to monitor the actions of the staff and will bring any behavior that is inconsistent with the staff code of conduct to the attention of someone in authority at the YMCA.

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

# YMCA CAMP CHANDLER

  

## Release and Waiver of Liability and Indemnity Agreement

In consideration for being permitted to utilize the facilities, services and programs of The Young Men's Christian Association of Montgomery, Inc. ("YMCA"), the undersigned, on behalf of himself or herself and his or her heirs, personal representatives and next-of-kin, does hereby agree to the following:

1. THE UNDERSIGNED HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE the YMCA, its successors and assigns, and its directors, officers, employees, and agents (collectively, the Releasees) from any and all claims, demands, damages, actions, causes of actions, or suits of whatever kind or nature arising or resulting from any loss or damage to property or injury or death to person, whether caused by the negligence of Releasees or otherwise, while he or she is in, upon, or about the premises of the YMCA or using any of its facilities, services or equipment, or participating in any program or activity offered by or affiliated with the YMCA.
2. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND HOLD HARMLESS the Releasees and each of them from any loss, liability, damage, or cost they may incur, whether caused by the negligence of the Releasees or otherwise, due to his or her presence in, upon, or about the premises of the YMCA or use of its facilities, services or equipment, or participation in any program or activity offered by or affiliated with the YMCA.
3. THE UNDERSIGNED HEREBY EXPRESSLY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE, whether caused by the negligence of Releasees or otherwise, while he or she is in, upon, or about the premises of the YMCA or using any of its facilities, services or equipment, or participating in any program or activity offered by or affiliated with the YMCA.

In the event of injury, the undersigned hereby authorizes the Releasees to provide or cause to provide such medical care and treatment to him or her as may be necessary and appropriate. The undersigned understands that he or she is solely responsible for all costs incurred for such medical care or treatment. The undersigned hereby gives his or her permission to the YMCA to use indefinitely, without limitation or obligation, photographs, film footage, or tape recordings which may include the image or voice of the undersigned for the purpose of promoting or interpreting YMCA programs and activities.

\_\_\_\_\_  
Name of Camper

**Parent or Guardian of Minor Child or Ward**

I, as parent or guardian of the above named minor, hereby give my permission for my child or ward to participate in any program or activity offered by or associated with the YMCA and further agree, individually and on behalf of said minor or ward, to be bound by all of the terms set forth above.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**INCOME ELIGIBILITY FORM  
SUMMER FOOD SERVICE PROGRAM  
(For Use by Camps and Closed Enrolled Sites)**

**To: The Household Member**

**From: The Official Representative of the Sponsor** \_\_\_\_\_

**Name of Organization** \_\_\_\_\_

**If you need help, please call this number.** \_\_\_\_\_

Please help us to comply with the requirements of the USDA Summer Food Service Program (SFSP). The information requested on this Income Eligibility Form (IEF) is necessary in order for us to receive reimbursement for meals served to participants in our center. The form will be placed in our files and will be treated as confidential information. Thank you.

**HOW TO COMPLETE THE INCOME ELIGIBILITY FORM:**

**Follow these instructions, if your household gets SNAP TANF or FDPIR:**

**Part 1:** List participant's name and a SNAP, TANF or FDPIR case number.

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Sign the form. A Social Security Number is NOT required.

**Part 5:** Answer this question if you choose to.

**If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:**

**Part 1:** Enter the child's name.

**Part 2:** Please contact us at [phone number of Sponsor]

**Part 3:** Complete this part if you are applying for other children in the household and you did not enter a SNAP, TANF or FDPIR case number in Part 1.

**Part 4:** Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.

**Part 5:** Answer this question if you choose to.

**ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:**

**Part 1:** List each participant's name.

**Part 2:** Skip this part.

**Part 3:** Follow these instructions to report total household income from last month.

**Column A—Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B—Gross income last month and how often it was received.** Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In box 2, list the amount each person got last month from welfare, child support, alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household.

Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

**Column C—Check if no income:** If the person does not have any income, check the box.

**Part 4:** An adult household member must sign the form and include the **last four digits** of his or her Social Security Number, or mark the box if he or she doesn't have one.

**Part 5:** Answer this question if you choose to.

**Privacy Act Statement:** This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly.

Non-discrimination Statement: In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

**Part 1. Children enrolled in Camp or Closed Enrolled Sites.**

|  |  |
|--|--|
| Names<br>(First, Middle Initial, Last) | SNAP, TANF or FDPIR case # (if any). <b>Skip to Part 4 if you listed a case #.</b> |
|  |  |
|  |  |
|  |  |

**Part 2. Foster Child**  
 Foster children are eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact [name of Sponsor] at [phone number]. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP, TANF or FDPIR case number in Part 1.

**Part 3. Total Household Gross Income—You must tell us how much and how often**

| A. Name<br>(List everyone in household, including children)<br><i>(Example)<br/>Jane Smith</i> | B. Gross income and how often it was received<br><i>Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly</i> |                                    |   |                     | C. Check if NO income    |
|--|--|------------------------------------|---|---------------------|--------------------------|
|  | 1. Earnings from work before deductions  | 2. Welfare, child support, alimony | 3. Social Security, pensions, retirement, | 4. All Other Income |                          |
|  | \$200/weekly   | \$150/weekly                       | \$100/monthly                             | \$ ____/____        | <input type="checkbox"/> |
|  | \$ ____/____   | \$ ____/____                       | \$ ____/____                              | \$ ____/____        | <input type="checkbox"/> |
|  | \$ ____/____   | \$ ____/____                       | \$ ____/____                              | \$ ____/____        | <input type="checkbox"/> |
|  | \$ ____/____   | \$ ____/____                       | \$ ____/____                              | \$ ____/____        | <input type="checkbox"/> |
|  | \$ ____/____   | \$ ____/____                       | \$ ____/____                              | \$ ____/____        | <input type="checkbox"/> |
|  | \$ ____/____   | \$ ____/____                       | \$ ____/____                              | \$ ____/____        | <input type="checkbox"/> |
|  | \$ ____/____   | \$ ____/____                       | \$ ____/____                              | \$ ____/____        | <input type="checkbox"/> |

**Part 4. Signature and Social Security Number (Adult must sign)**  
 An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)  
 I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.  
 Sign here: X \_\_\_\_\_ Print name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Last four digits of Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_  I do not have a Social Security Number

**5. Participant's ethnic and racial identities (optional)**

|   |  |
|---|--|
| Mark one ethnic identity:<br><br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Not Hispanic or Latino | Mark one or more racial identities:<br><input type="checkbox"/> Asian<br><input type="checkbox"/> White<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> American Indian or Alaska Native<br><input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
|---|--|

**DON'T FILL OUT THIS PART. THIS IS FOR OFFICIAL USE ONLY.**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12  
 Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks,  Twice A Month,  Month,  Year  
 Household size: \_\_\_\_\_  
 Categorical Eligibility: \_\_\_ Date Withdrawn: \_\_\_\_\_ Eligibility: Free \_\_\_ Reduced \_\_\_ Denied \_\_\_  
 Reason: \_\_\_\_\_  
 Temporary: Free \_\_\_ Reduced \_\_\_ Time Period: \_\_\_\_\_ (expires after \_\_\_ days)  
 Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Important Information about Camp WheezeAway

### **Application Deadline is May 1, 2019 to be considered for camp**

Please mail or fax completed application with all necessary attachments and information to:

**Camp WheezeAway  
YMCA Camp Chandler  
1240 Jordan Dam Road  
Wetumpka, AL 36092  
Fax: 334-649-7516**

**Campers will be notified in May 2019**



**Camp Location:  
YMCA Camp Chandler  
1240 Jordan Dam Road  
Wetumpka, AL 36092  
[www.campchandler.org](http://www.campchandler.org)**



- Arrival:** If your camper is accepted, arrival for your camper will be the first day of the camper session, Sunday, May 26, 2019 between 1:00 p.m. and 3:00 p.m. central time. **Parents or the person bringing the camper to camp must stay with the camper until registration is complete.**
- Departure:** Departure will be on the last day of the camper's session, **Friday May 31, 2019 between 9 AM and 11 AM central Time. PLEASE DO NOT BE LATE!**
- Acceptance Fee:** A \$20.00 acceptance fee (due by May 1) is required once accepted, to reserve your child's spot and is non-refundable. This fee will cover the camp T-shirt and a daily visit to the Camp Store for one drink and one snack item.
- Visiting:** Parents, relatives, and friends of the campers are welcome to visit and tour the facility, on arrival and departure days only!
- Food:** The campers and staff of Camp Chandler will be served three nutritious, well-planned meals daily. Please do not send or bring food to Camp. Please make sure the medical staff is aware of any food allergy your camper may have.
- Phone:** Cell Phones are not allowed at Camp. You may call Brenda Basnight (334) 799-3449 to check on your child during the week of camp.
- Staff:** Trained staff will be with the campers at all times. Counselors sleep in the cabins with the campers. A physician along with registered nurses and respiratory therapists are on 24 hour duty, and emergency care arrangements have been established. We feel certain there are positive experiences in store for your camper this summer at Camp Chandler/Camp WheezeAway. We assure you that the staff is highly qualified to meet all needs.

**If you have any questions about CAMP WHEEZEAWAY prior to camp, please call Brenda Basnight, CRT at (334) 799-3449 or Email: [brendabasnight@yahoo.com](mailto:brendabasnight@yahoo.com)**

**If you have questions about Camp Chandler, please call the YMCA Office at (334) 229-0035.**