

# Town of Ticonderoga Summer Program 2026

Monday, July 6 through Friday, August 7  
7:30 AM to 2:30 PM

Ticonderoga Elementary School

Please use the main office entrance at the front of the building.

The registration fee is \$50.00 per child.

Pick up forms at the Town Clerk's Office or print the forms from the Town's website [www.townofticonderoga.gov](http://www.townofticonderoga.gov) under the Youth Commission section.

Submit the registration, medical, health record forms, and payment to the  
Town Clerk.

**Pre-Registration and payment is required.**

You can choose to send your child to the program every day, or you can choose what days your children will attend.

If you should have any questions, please contact the Town Clerk's Office at (518)-585-6677.

# Town of Ticonderoga Summer Program 2026

Age 5 to age 13

Registration fee \$50.00 per child

Parent/Guardian Name:

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Address

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Phone \_\_\_\_\_

Name and age of the children that you are  
registering, as well as the dates attending for  
the Summer Program

Name

Age

Dates Attending

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Signature \_\_\_\_\_

Date \_\_\_\_\_

# Ticonderoga Summer Youth Program

Camper Health History Form  
Developed and Reviewed by American Camp Association  
Academy of Pediatrics Council on School Health and  
association of Camp Nurses

Return this form to:  
PO Box 471  
132 Montcalm Street  
Ticonderoga, NY 12883

Dates will attend camp: From \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Gender (please circle):      Male      Female      Current Age: \_\_\_\_\_

Camper Home address \_\_\_\_\_  
Street/Town/State/Zip

Parent/guardian with legal custody to be contacted in case of illness or injury.

1<sup>st</sup> Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Preferred Phones (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

2<sup>nd</sup> Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Preferred Phones (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

3<sup>rd</sup> Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Preferred Phones (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

**Allergies** {  } No Known Allergies {  } This camper is allergic to:

{  } Food {  } The environment (insect stings, hay fever, etc.)

Other (Please describe below what the camper is allergic to, and the reaction seen)

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

**Diet/ Nutrition:**

- This camper eats a regular diet       This camper eats a regular vegetarian diet
- This camper has special food needs. (Please describe below.)

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**Restrictions:**

- I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
- I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (*Please describe below.*)

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**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber Insurance Company Phone Number ( \_\_\_\_ ) \_\_\_\_\_

**Parent/Guardian Authorization for Health care:**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order X-rays, routine test, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order Injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need-to-know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name \_\_\_\_\_  
 First/Middle/Last

Birth date: \_\_\_\_\_  
 Month/Day/Year

Immunization	Dose 1 Month Near	Dose 2 Month Near	Dose 3 Month Near	Dose 4 Month Near	Dose 5 Month Near	Most recent Dose Month/Year
Diphtheria, Tetanus, Pertussis* (DTap) or (Tdap)						
Tetanus booster* (dT) or (TdaP)						
Mumps, Measles, Rubella* (MMR)						
Polio* (IPV)						
Haemophilus Influenzae type B (HIB)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) <input type="checkbox"/> Had Chicken Pox Date:						
Meningococcal meningitis MCV4						

*Immunization History: Provide the month and year for each immunization. Starred (\*) immunizations must be current.  
 Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to  
 this form.*

Tuberculosis TB test Date: \_\_\_\_\_  Negative  Positive

If your camper has not been fully immunized, please sign the following statement. I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: \_\_\_\_\_

Date \_\_\_\_\_ Relationship to camper \_\_\_\_\_

- Medication:**  This camper will **not** take any daily medications while attending camp
- This camper will take the following daily medication(s) while at camp.

“Medication” is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please review camp instructions about required containers. Many states require containers with labels which show the camper’s name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:		

A camper who has prescribed medications shall have a specific written order that is signed by a licensed prescriber, describing use of the medication and is required in order to self-administer a medication.

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

***Has/Does the camper:***

Ever been hospitalized?  Yes  No

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Ever had surgery?  Yes  No

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Have recurrent/chronic illnesses?  Yes  No

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Had a recent infectious disease?  Yes  No

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Had a recent injury?  Yes  No

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Had asthma/wheezing/shortness of breath?  Yes  No

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Have diabetes?  Yes  No

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Had seizures?  Yes  No

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Had Headaches?  Yes  No

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Wear glasses, contacts or protective eyewear.  Yes  No

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Had fainting or dizziness?  Yes  No

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Passed out/ had chest pain during exercise?  Yes  No

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Had mononucleosis "mono") during the past 12 months?  Yes  No

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If female have problems with periods/menstruation?  Yes  No

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Have problems with falling asleep/sleepwalking?  Yes  No

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Ever had back/joint problems?  Yes  No

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Have a history of bedwetting?  Yes  No

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Have problems with diarrhea/constipation?  Yes  No

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Have any skin problems?  Yes  No

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**Mental, Emotional, and Social Health: Check “Yes or “No” for each statement.**

***Has the camper:***

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?  Yes  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?  Yes  No
3. During the past 12 months, have seen a professional to address mental/emotional health concerns?  Yes  No
4. Had a significant event that continues to affect the camper’s life?  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain “Yes” answers in the space below, noting the number of questions. The camp may contact you for additional Information.

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**Health Care Providers**

Name of camper’s primary doctor(s):

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Phone: \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_

Phone: \_\_\_\_\_

What have we forgotten to Ask? Please provide in the space below any additional information about the camper’s health that you think important or that may affect the camper’s ability to fully participate in the camp program. Attach additional information if needed.

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Date: \_\_\_\_\_

Camper Name: \_\_\_\_\_  
First/Middle/Last

Birth date: \_\_\_\_\_  
Month/Day/Year

### Individual Health Record (For Camp Use Only)

Initial Screening Date/Time: \_\_\_\_\_

Initials: \_\_\_\_\_

Screening has been conducted according to camp protocol and significant findings as noted as follows:

A. Any signs or symptoms of illness or injury upon arrival?

No  Yes as noted Below.

B. History of exposure to communicable disease?

No  Yes as noted below.

C. Additions or corrections to information on this health history?

No  Yes as noted below.

D. Medication given to healthcare staff.

No  Yes as noted below.

E. Any signs/symptoms of head lice?

No  Yes as noted below.

Provider notes: (date/time/ initial all entries) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Exit Note: Check one of the following:

Left camp this day with no reported illness or injury symptoms.

Left camp this day with the following problem/concern: \_\_\_\_\_  
\_\_\_\_\_

This person was told about the problem and instructed about follow-up as noted above:

Date/Time: \_\_\_\_\_ Initials: \_\_\_\_\_