Summer 2025
Camper Application Form

Camp Exclamation Point (CAMP!) is a week-long residential summer camp for underserved rural Vermont kids. We offer a core program of experiences and activities in art, music, environmental science, physical activity, water safety, nutrition, self-care, and literacy. It is a safe and welcoming environment for kids to be kids, where good citizenship is modeled and encouraged, and we empower children to make meaningful personal decisions, learn responsibility and build self-esteem. We strive to provide a stable and rewarding experience that our campers enjoy returning for each summer, and to make this experience available to their brothers and sisters. CAMP! is located at Camp Farnsworth in Thetford, VT, a lovely facility including the private 50-acre Lake Abenaki, owned by the Girl Scouts of the Green and White Mountains.

To apply for your child/children to attend camp, please read the following information carefully.

The dates for camp are **Sunday, August 10 to Saturday, August 16.**

Application Deadlines:
- Returning Campers and Siblings: **March 31, 2025**
- New Campers: **April 30, 2025**

Campers must be currently enrolled in **grades 2 through 7** (as of March 2025) in order to attend. Each camper must have their own application and health form.

The factors for determining **camper eligibility** are 1) financial need, 2) rural (geographic) isolation, 3) disruption of life and education due to frequent moves, and 4) family (parent or guardian) involved in agricultural work. It is not necessary for applicants to meet all criteria.

All campers (and staff) will likely be asked to take a COVID-19 test (antigen or PCR) prior to arriving at camp. Being current with a COVID-19 vaccination/booster is not required but is strongly recommended.

Important: Applications for new campers must include a **letter of introduction** from a teacher or school counselor. This letter should refer to the eligibility criteria noted above, as well as be a general introduction to the child. Please reference any behavioral concerns that we should be aware of or that might cause a challenge in a residential camp setting; it is essential for us to know this information in advance so we can provide the best experience for the child and for all our campers.

There is a **$30 deposit per camper**. The check should be made payable to CAMP!; do not send cash.

For each camper, please submit:
❑ Application ❑ Letter of Introduction (new campers) ❑ Health Information Form ❑ Check for $30

For each family, please submit: ❑ Application for Free and Reduced Price School Meals

Mail completed forms and a check for the deposit(s) to: CAMP!, P.O. Box 91, Richmond, VT 05477

If you have questions about the registration process, or about camp in general, please contact me by e-mail at campexclamationpoint@gmail.com, or by phone at 855-802-CAMP.

Scott Moore, Managing Director

Summer Food Service Program Information

Dear Parent/Guardian,

Providing free and nutritious meals to children is a growing financial challenge and requires our taking advantage of all available funding resources. One resource is the Summer Food Service Program (SFSP), a cash reimbursement program from the United States Department of Agriculture (USDA). The reimbursements are very helpful and aid us in providing better services to campers.

In order for us to receive the maximum funds possible, we need information from you. This information will be kept strictly confidential. Please complete, sign, and return the attached Application for Free and Reduced Price Meals with your child's application. This is the same form you may have used for meal programs at your child's school. **Only one form is needed per household.** If you have questions on how to fill out the form, please email campexclamationpoint@gmail.com or call 855-802-2267 and choose the "Managing Director" option.

Please list any food allergies on your child's Health Information Form. If your child has a disability that prevents them from eating the meals provided at our site, we will make substitution(s) prescribed by your doctor at no charge to you. Please include a doctor's note that prescribes the alternative food(s) needed with your child's application.

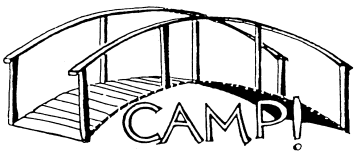
Thank you for your cooperation.

* * *

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, visit this website: https://www.usda.gov/about-usda/general-information/staff-offices/office-assistant-secretary-civil-rights/how-file-program-discrimination-complaint or any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the online form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Camper Application
(Please print clearly.)



Return completed application to:
CAMP!
P.O. Box 91
Richmond, VT 05477

Date of Application: _____

Camper's Name: _____ Identified Gender: _____

Preferred Name/Nickname: _____ Pronouns: _____

Date of Birth: _____/_____/_____ Current Grade *(as of 1/1/25)*: _____

School Name/Town: _____

Parent/Guardian Name(s): _____

Mailing Address: _____
Street & Number *City* *State* *ZIP*

Phone:
Home _____ Mobile _____Work _____

E-mail: _____
Best contact(s): □ Home □ Mobile □ Work □ E-mail

Does this child and/or the family have a connection to agriculture? _____

_____

Has this child attended summer camp before? □ Yes, CAMP! □ Yes, other camp(s) (see below) □ No

Which other camp(s) and year(s) did they attend? _____

_____

What is your child's primary spoken language? _____

Does your child need assistance with communicating in English? Yes_____ No_____

If yes, please describe: _____

Is this child currently receiving services from:

□ VT Migrant Education Program □ Department of Children and Families (DCF)

□ Reach Up □ 3 Squares VT Case Number: ____ ____ ____ - ____ ____ - ____ ____ ____ ____

□ Other_____

T-shirt Size (circle): **Youth:** S M L XL **Adult:** S M L XL Other_____

(Application continues on the next page)

CAMP! has an all-volunteer staff with diverse backgrounds and careers, but most do not have professional experience working with children. Campers must be able to transition between activities on their own, and they have an hour of "free time" every day. Our camp includes natural features that could be dangerous to a camper who is unable to manage their impulses or follow directions, including a lake, a ravine, acres of forest, and roads. We appreciate any information and guidance that you can give our volunteers in helping your child have a successful and fun week at camp. Please share anything you think we should know so that we can best support your child, including:

- Have there been any difficult life situations which may be relevant to your child's experience this summer, including those involving counseling?
- Does your child have any behavioral patterns that might pose a challenge at a residential camp with the natural features noted above? Could they be a danger to themselves or to others? If so, how do you and your child's school manage those situations?
- Does your child require any other type of special assistance during the school day?

_____

_____

_____

_____

_____

_____

Camp Exclamation Point Behavior Policy

CAMP! has guidelines for campers designed to make camp a safe, fun, and positive place for all. If a camper is unable or unwilling to live within those guidelines, and interferes with the goals of camp, they will be sent home. Families are responsible for prompt transportation. No exceptions.

Camper: please read and sign.

I want to come to CAMP!, and I agree to follow the camp behavior guidelines. I understand that I will be asked to leave CAMP! if I am unable or unwilling to live up to this commitment.

Signature of camper _____ **Date** _____

Parent/Guardian: please read and sign.

I have read CAMP!'s behavior policy and agree to be responsible for transporting my child home from camp if he/she is asked to leave due to inappropriate behavior. I give permission for my child to participate in all supervised camp activities. I agree that any photographs or videotaping of those activities may include my child for the camp archives and for promotional reasons, or I will contact CAMP! in writing to request otherwise.

Signature of parent or guardian _____ **Date** _____

Camp Exclamation Point – Camper Health Information Form

*****This form must be filled out completely and accurately*****

This health history is essential for CAMP! in taking care of your child. All information will remain with the Camp Health Center and be treated as confidential, with the exception of cases when it will help your child receive necessary medical care.

Camper's Name: _____ Date of Birth: ____/____/____

Health History: Please mark **yes** or **no** below. Date of last physical exam _____

Hearing problems	□ Yes	□ No	Diabetes	□ Yes	□ No
Ear tubes	□ Yes	□ No	Scabies	□ Yes	□ No
Hearing Aid	□ Yes	□ No	Seizures	□ Yes	□ No
Earaches	□ Yes	□ No	Headaches	□ Yes	□ No
Vision problems	□ Yes	□ No	Sore throats	□ Yes	□ No
Uses eyeglasses	□ Yes	□ No	Upset stomach	□ Yes	□ No
Heart problems	□ Yes	□ No	Bladder infection	□ Yes	□ No
Speech impairment	□ Yes	□ No	Frequent colds	□ Yes	□ No
Asthma	□ Yes	□ No	Head lice	□ Yes	□ No
Sinus problems	□ Yes	□ No	Bedwetting	**Frequently**	**Rarely** **Never**
Chicken pox	□ Yes	□ No	Sleepwalking	**Frequently**	**Rarely** **Never**

Please explain any responses answered "yes" and include appropriate dates. _____

_____

_____

Immunization Record: Please give **dates** of most recent immunization (do not write "up to date") or enclose copy of immunization forms. Contact your physician if you have questions.

COVID-19 _____ **DPT** _____ **MMR** _____ **DT** _____

OPV _____ **Hep B** _____ **Tetanus** _____

Medications currently taken:

****All medications brought to camp must be in the original pharmacy containers****

(Name of medication)	(Amount/dose)	(Reason for taking)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe any allergic reactions to medications, foods, plants, or animals including insect bites/stings?

Allergy:_____ Reaction/severity: _____

Allergy:_____ Reaction/severity: _____

Allergy:_____ Reaction/severity: _____

Allergy:_____ Reaction/severity: _____

Does your child carry an EpiPen? □ Yes □ No

Any recent serious illnesses or hospitalizations we should know about? _____

_____

Should your child be restricted from certain activities due to health problems or behavioral concerns? If yes, please explain.

_____

_____

_____

Are there any other health issues that CAMP! should know about? □ Yes □ No If yes, please explain_____

_____

Physician's name _____ Phone number _____

Dentist's name _____ Phone number _____

Is the child covered by health insurance? □ Yes □ No If yes, give name of company and policy number:

_____

Is the child covered by Medicaid? □ Yes □ No If yes, give Medicaid number. _____

Primary Contact Name _____ **Relationship to camper** _____
Home phone _____ **Mobile** _____**Work** _____
Emergency Contact who would know where you are in case we cannot reach you in an emergency concerning your child:
Name _____ **Relationship to camper** _____
Home phone _____ **Mobile** _____**Work** _____

EMERGENCY RELEASE AUTHORIZATION This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. In case of emergency or illness, CAMP! will make every effort to contact me. If CAMP! is not able to reach me, or if immediate action or treatment is judged necessary, I hereby authorize CAMP! to arrange emergency medical care, including transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary.

I give CAMP! permission to treat my child for head lice, if found. □ Yes □ No If no, parents will need to treat child themselves before camper can stay overnight.

Signature of parent/guardian_____ **Date** _____

Printed Name_____ **Relationship to camper**_____

I also understand and agree to abide by the restrictions placed on my participation in camp activities.

Signature of camper or minor staff_____ **Date**_____

Screening Record

Meds received_____

_____

Updates/additions to health history noted □ Yes □ No □ None required

Current health needs identified_____

_____

Screened by_____ Time_____am/pm Temp_____ Date_____

2024-2025 Vermont Application for Free and Reduced Price School Meals

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
RETURN TO (School/District Name):
ADDRESS:

STEP 1 **List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.**

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Grade	School Name (if Applicable)	Check all that apply: Foster Child	Migrant	Runaway	Homeless
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 **Do any household members (including you) participate in: 3SquaresVT, or Reach Up?**

○ **NO** ➔ Go to STEP 3. ○ **YES** ➔ Write case number here and proceed to STEP 4.

Case Number (Not EBT Card Number): _ _ _ – _ _ – _ _ _ _

STEP 3 **List ALL household members and income for each member (before taxes and deductions)**

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.) Attach another sheet of paper if you need space for more names. List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received? Per Week	Every 2 Weeks	2x Month	Per Month	Per Year	Public Assistance, Child Support, Alimony	How often received? Per Week	Every 2 Weeks	2x Month	Per Month	All Other Income*	How often received? Per Week	Every 2 Weeks	2x Month	Per Month
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Number of Household Members (Children and Adults) ☐

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (If Applicable) ☐☐☐☐

Check box if no Social Security Number ☐

*All Other Income Including Pensions, Retirement, Social Security, SSI, or VA Benefits

Please see application's back for a list of income sources.

B. Child Income

Sometimes children in the household earn or receive income.
Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income	How often received? Weekly	Every 2 Weeks	2X Month	Monthly	Annual
$	○	○	○	○	○

STEP 4 **Contact information and adult signature.**

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form _____ Signature of Adult _____ Today's Date _____

Mailing Address (if available) _____ City _____ State _____ Zip Code _____

Phone Number (Optional) _____ Email Address (Optional) _____

SOURCES AND EXAMPLES OF INCOME

For additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children
Earnings from Work	Public Assistance, Alimony, and Child Support	Pensions, Retirement, All Other Sources of Income	

• Salary, wages, cash bonuses, tips, commissions
• Net income from self-employment (farm or business)
• **If you are in the U.S. Military:**
  ○ Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances)
  ○ Allowances for off-base housing, food, and clothing
	• Unemployment benefits
	• Workers' compensation
	• Supplemental Security Income (SSI)
	• Cash assistance from State or local government Alimony payments
	• Child support payments
	• Veterans' benefits
	• Strike benefits
		• Social Security/Disability (including railroad retirement and black lung benefits)
		• Private Pensions or disability benefits
		• Income from trusts or estates
		• Annuities
		• Investment income
		• Earned interest
		• Rental income
		• Regular cash payments from outside household
			• A child has a regular full or part-time job where they earn a salary or wages
			• A child is blind or disabled and receives Social Security benefits
			• A parent is disabled, retired, or deceased and their child receives Social Security benefits
			• A friend or extended family member regularly gives a child spending money
			• A child receives a regular income from a private pension fund, annuity, or trust

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

DO NOT FILL OUT

For school use only.

Annual Income Conversion: Weekly × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income	Weekly	Every 2 Weeks	2x Month	Monthly	Per Year

Household Size

Categorical Eligibility
☐

Eligibility		
Free	Reduced	Denied
☐	☐	☐

Determining Official's Signature _____ Date _____

Confirming Official's Signature _____ Date _____

Verifying Official's Signature _____ Date _____

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number'. Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number.

Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

Other Information: For information on free or low-cost health insurance contact Green Mount Care at 1-800-8427 or www.GreenMountainCare.org. For information on 3SquaresVT to help with food costs call 1-800-479-6151.

The contact information below is solely to file a complaint of discrimination:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or
(2) FAX: (833) 256-1665 or (202) 690-7442; or
(3) Email: program@intake@usda.gov

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