## CAMP LOYALTOWN 2020 MEDICAL INFORMATION PAGE

Campers Name: ____________________________________________

Dear Parents and Guardians,

Please submit this entire packet with the required information attached, signed and dated by a health care provider. The medical forms, information and dates must encompass the camper's entire stay at camp during the 2020 season.
All forms are due no later than **February 1, 2020**.

To ensure a place in camp, the medical packet must be received, signed and completed in it's entirety by February 1st. If it is not time/too early for your camper's regular physical exam, ask your health provider for a "camp assessment and camp clearance appointment."

***** PLEASE BE ADVISED IF YOUR CAMPER'S MEDICAL FORMS ARE NOT COMPLETED IN THEIR ENTIRETY AND SIGNED/STAMPED BY A HEALTH CARE PROVIDER, THEY MAY BE RETURNED**. ***

1. ☐ **ANNUAL PHYSICAL EXAM/CAMP PHYSICAL EXAM/CAMP ASSESSMENT-** Camp Loyaltown (or AHRC) ANNUAL PHYSICAL EXAM (MUST COVER THE INDIVIDUAL FOR THE DAYS THEY ARE ATTENDING CAMP). 2020 Physical/camp assessment paperwork must be dated within 365 days prior to the start of the camp session. The Medical clearance needs to be completed for 2020 as well.
    - The annual physical/camp assessment ***must*** include all medication orders and treatments prescribed to camper.
    - The annual physical/camp assessment Physician's orders ***must*** include any prescription medications, routine OTC (over the counter), vitamins, dietary supplements, inhalers, liquids, allergy medications, g-tube feedings etc.
2. ☐ **PRN MEDICATION ADMINISTRATION FORM**
    2020 Camp Authorization for PRN Medication Administration Form
3. ☐ **MEDICAL CLEARANCE FORM**
    2020 Medical Clearance form, signed and stamped by physician
4. ☐ **Copy of FULL Immunization Record.** (signed and dated by the physician)

- New York State Public Health Law (NYS PHL) §2164 Subpart 7-2 of the New York State Sanitary Code requires camps to maintain immunization records for all campers which includes dates for all immunizations against diphtheria, Haemophilus influenza type b, hepatitis b, measles, mumps, poliomyelitis, rubella, varicella and tetanus booster within the last 10 years. The record must be kept on file for every camper and ***updated annually.*** Greene County Department of Health mandates proof of Measles immunity.

**A full vaccination record with signature from the Health care provider can be attached.**

Please provide evidence of 2 Measles vaccines or positive Measles titers.

5. ☐ Specific Medical Guidelines/Protocols; e.g. insulin, bowel (Please send Physician's orders)
    ☐ **Not** Applicable
6. ☐ Copy of Adaptive Equipment Guidelines
    ☐ **Not** Applicable
7. ☐ Copy of Specialized Eating/Nutrition Guidelines
    ☐ **Not** Applicable

**CAMP LOYALTOWN CAMPER INSURANCE INFORMATION 2020**

Camper's name: ______________________________

**PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE, MEDICAID, AND/ OR MEDICARE CARDS IN THE BOXES BELOW.**

***(Please make sure all copies are clear and legible).***

**Please be aware Camp is not responsible for any medical copayments**

| F R O N T | B A C K |
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| F R O N T | B A C K |
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| | |

# CAMP LOYALTOWN PHYSICAL EXAM 2020

**Name**________________________________

Date of Birth: _________________________

Date of Exam: ________________________

**ALLERGY**

NKA ☐ __________________________

Medication ☐ __________________________

Food ☐ ___________________________

Environmental ☐ ___________________________

EPI-PEN ☐ ___________________________

## Medical History

| Medical/Psychiatric Issues | Surgeries | Implanted devices: |
|---|---|---|
| ________________________________<br>________________________________<br>________________________________<br>________________________________<br>________________________________<br>________________________________<br>________________________________<br>________________________________ | ________________________________<br>________________________________<br>________________________________<br>________________________________<br>________________________________<br>________________________________<br>________________________________<br>________________________________ | ☐ Shunt<br>☐ Insulin pump<br>☐ Glucose Monitor<br>☐ Baclofen pump<br>☐ Pacemaker<br>☐ VNS<br>☐ **OTHER**:<br>______________<br>______________ |

## MEDICATIONS

**All medications (including vitamins, supplements & over the counter medications) the individual takes should be listed here or attached to this form, an additional page can be added and signed by the doctor and must include all categories listed below. Medication administration times at camp are typically 9am, 1pm, 5:30pm, 8pm, other times may be accommodated, please note desired med times below.**

| Medication/ Strength (mg or ml) | Dose and Frequency | Route | Indication/Desired Effect | Special Comments: include special directions, i.e. Crushed given in applesauce, etc. |
|---|---|---|---|---|
| EXAMPLE ONLY Acetaminophen 325mg | 2 tabs Twice a day | By mouth | Pain relief | Whole with Water |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## EMERGENCY PRN MEDICATION PROTOCOLS

(i.e. for activity or behavioral issues)

| Purpose (ie. Medication protocol /Behavior) | Medication | Doses, frequency | Route | Special Considerations |
|---|---|---|---|---|
| | | | | |

## Medical Guidelines/Protocols (i.e. insulin, bowel, tube feedings)

| |
|---|
| |

# CAMP LOYALTOWN PHYSICAL EXAM 2020

Name: ________________________________

Height _________ BP ___________ Pulse/o2% _________

Weight ________ Temp__________ Respirations _________

| |
|---|
| Skin<br><br>Risk For Break down?: |
| Head/Neck/Thyroid: |
| Nose/Throat: |
| Eyes/Vision: Right Left<br><br>Corrective Lenses: ☐ yes ☐no |
| Ears/Hearing:<br><br>Hearing Aids: ☐ yes ☐ no |
| Dentition:<br><br>Dentures : ☐yes ☐no |
| Neuro/Behavioral:<br><br>Seizures: ☐yes ☐no |
| Cardiac:<br><br>EKG Abnormalities: |
| Chest/Breast Exam:<br><br>Mammogram Abnormalities: |
| Pulmonary: |
| Abdomen/GI: |
| Recto/Procto: |
| Renal/Urinary: |
| Genitalia/Gynecological:<br><br>Pap Smear Abnormalities: |
| Back/Spine/Extremities: |
| Other |

**MOBILITY LIMITATIONS/RESTRICTIONS:**

| Activity | OK | Avoid | Limit | Describe Limit |
|---|---|---|---|---|
| Walking | ☐ | ☐ | ☐ | ____________________ |
| Kneeling | ☐ | ☐ | ☐ | ____________________ |
| Pulling | ☐ | ☐ | ☐ | ____________________ |
| Pushing | ☐ | ☐ | ☐ | ____________________ |
| Reaching | ☐ | ☐ | ☐ | ____________________ |
| Standing | ☐ | ☐ | ☐ | ____________________ |
| Lifting | ☐ | ☐ | ☐ | ____________________ |

**DIETARY GUIDELINE/RESTRICTIONS**:

Diet:_________________________________________

_____________________________________________

_____________________________________________

_____________________________________________

**ADAPTIVE EQUIPMENT/SCHEDULE OF USE:**

For all campers that require a shower chairs, a seat belt will be used unless specified otherwise.

_____________________________________________

_____________________________________________

_____________________________________________

**Physician signature** ______________________________

**Date:** __________

**(Print or Stamp)**
**Physician Name**______________________________

**Address** ______________________________________

**Telephone # (       )** _______________________

# CAMP LOYALTOWN MEDICAL CLEARANCE 2020

***Physician: Please keep in mind the safety of the individual in your care by reading the following information about Camp Loyaltown.***

Camp Loyaltown is a summer sleep away camp located in the Catskill Mountains in Hunter NY, immediately opposite Hunter Mountain Ski Resort; we serve individuals with developmental and other disabilities ranging in age from 5 to 80 years plus.

**ACCOMODATIONS:**

- Modern rustic cabins, some buildings are wheelchair accessible
- Heated, with ceiling fans, and air conditioning
- Communal barrack style living; counselors reside with campers

**WEATHER**

- Summer temperature can range from 40 to 90 + degrees Fahrenheit
- Summer humidity can range from low to moderately high

**TERRAIN:**

- Hilly at times uneven ground
- Paved roads

**MEDICAL CARE:**

- RN's and LPN's living on camp grounds
- Health Center is air conditioned
- The nearest physician is located approximately 20 miles or at least 30 minutes away from the camp
- There is EMS Service to the Mountaintop area
- The closest hospitals are: Columbia Hospital, Hudson, NY and Kingston Hospital, Kingston, NY – approximately 60 minutes from the camp even by ambulance.

*************************************************************************************************

**It is my opinion that (Camper's Name): ______________________________ D.O.B.___/___/____**

☐ **Has no** health condition or concern regarding side effects of currently prescribed medication that requires any activity restriction in our camp setting.

☐ The individual should follow the following Activity Restrictions: _________________________________

**Please check if the individual is able & interested in participating in the Horseback Program at Camp Loyaltown.**

☐ Given the individual's diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. The individual may participate in therapeutic riding or equine assisted activities at the discretion of the camp's qualified on-site staff.

**Medical Provider's Signature**: _______________________________ Circle one: M.D. D.O. C.N.P. P.A.

**Date signed: _____/_____/_____**

| **This form MUST be stamped by health provider** |
| --- |
| |

**CAMP LOYALTOWN**

**AUTHORIZATION TO ADMINISTER PRN (AS NEEDED) NON-PRESCRIPTION MEDICATION** *As required by New York State Office for People with Developmental Disabilities* If there are medications listed that the doctor does not want the individual to be treated with, the doctor may cross out those medications or treatments and write in their preferred drug or treatment

| **INDIVIDUAL:** | **ALLERGIES:** | **DOB:** | **DOSAGE:**<br>☐**ADULT** ☐***CHILD**** <br>*see below* |
|---|---|---|---|

**PRIMARY CARE PHYSICIAN Please review changes as needed, and sign below. This order is in effect until 1 year from date of signatures below.**

| **PHYSICAL SIGNS OR SYMPTOMS** | **MEDICATION / TREATMENT** | **ADULT DOSAGE / ROUTE** **Adjust for Child as per manufacturer's guidelines* | **FREQUENCY** | **MAXIMUM DOSAGE 24-HOUR PERIOD** |
|---|---|---|---|---|
| **ABRASIONS** | Triple Antibiotic Ointment<br>Bactine spray | Bactine to wound, wash with soap & water.<br>Apply antibiotic ointment to area and cover with dry dressing.<br>Spray to affected area | Reassess wound site based on initial assessment or as individual may need | Based on initial assessment |
| **ALLERGIC REACTION TO INSECT BITE OR HIVES Poison Ivy, Itchy Rash** | Benadryl , Ice, Calamine or<br>Hydrocol 1% cream | Benadryl 25 mg po<br>Topical to affected area | Every 6 hrs PRN<br>Every 4 hrs PRN | 4 doses daily<br>6 doses daily |
| **ANAPHYLACTIC REACTION** | **Epi-Pen SC** | **As per manufacturer's guidelines** | PRN | **Take immediately to ER by ambulance.** |
| **ATHLETE'S FOOT** | Tinactin Cream or<br>Desenex Powder | Topically to affected area | BID PRN | |
| **BURNS** (1st degree) reddened & injured skin without blister | Cool Compress | Topically to affected area | PRN – if blister forms to be seen by MD | If blister forms to MD |
| **CHEST PAIN -Call ambulance** | Baby Aspirin 81mg (chewable) | 4 tablets chewed po | As directed by MD/ RN | As directed by MD/ RN |
| **CONSTIPATION** (difficult or no bowel movement in 3 days) | Milk of Magnesia<br>Senna tabs<br>Miralax Powder<br>Glycerin Suppository<br>Fleets Enema | Milk of Magnesia 30 ml po<br>Senna Tabs 2 po<br>Miralax Powder-adults 17 yrs and older; stir and dissolve 1 packet powder (17g) in any 4-8 oz of beverage; then drink; use once a day; no more than 7 days<br>Glycerin Supp PR<br>Fleets Enema PR daily PRN | Daily PRN<br>Daily PRN<br>Daily PRN<br>Daily PRN<br>Daily PRN | Daily PRN |
| **COUGH** (cough that disrupts resident's sleep, comfort ) | Robitussin DM Cough Syrup | Robitussin DM Cough Syrup 10 ml po | Q 4 hrs PRN | 4 doses daily. |
| **DIARRHEA** (2 or more watery stools in 24 hours)<br>Light diet, banana, rice, toast, tea, and applesauce. | Light diet, (B R A T T Diet )<br>Pepto-Bismol | Light diet until normal bowel movement returns<br>Pepto-Bismol 30 ml po | Each meal daily PRN<br>Every 6 hrs PRN | 4 doses daily |
| **ELEVATED TEMPERATURE** (oral temperature 100.4 or more, axillary temperature 99.6 or more, rectal temperature 101 or more tympanic temperature 101 or more) | Acetaminophen<br>Ibuprofen | Acetaminophen 650mg po<br>Ibuprofen 400mg po | Every 4 hrs PRN<br>Every 4 hrs PRN | 4 doses daily<br>4 doses daily |
| **GENERAL DISCOMFORT; HEADACHE** without meningeal signs; **MENSTRUAL CRAMPS** | Acetaminophen<br>Ibuprofen/Motrin | Acetaminophen 650 mg po<br>Ibuprofen/Motrin 400mg po | Every 4 hrs PRN<br>Every 4 hrs PRN | 4 doses daily<br>4 doses daily |
| **GUM, MOUTH SORENESS** | Ambusol gel<br>Acetaminophen<br>Ibuprofen | Apply to area of gum soreness<br>Acetaminophen 650 mg po<br>Ibuprofen 400 mg po | Every 4 hrs PRN<br>Every 4 hrs PRN<br>Every 4 hrs PRN | 6 times daily<br>4 doses daily<br>4 doses daily |
| **INDIGESTION** | Pepto-Bismol<br>Antacid tabs<br>Mylanta liquid | Pepto-Bismol 30 ml po<br>Antacid 2 tablets po<br>Mylanta liquid 30 ml po | Between meals and H.S.<br>Every 4 hrs PRN<br>Every 4 hrs PRN | 4 doses daily<br>4 doses daily<br>4 doses daily |
| **NASAL CONGESTION** | Phenylephrine | 10 mg po 1 tab | Every 4 hrs PRN | 4 doses daily |
| **PUNCTURE WOUND** | Triple Antibiotic Ointment | wash wound with soap and water then Apply abx ointment, cover with dry drsg.; Review date of last Tetanus Injection and determine need for medical evaluation | Reassess wound based on initial assessment or as individual may need. | Based on initial assessment |
| **SORE THROAT**<br><br>**SORE THROAT WITH DEEP REDNESS/ PATCHES** | Acetaminophen<br>Ibuprofen<br>Cepacol Lozenges<br>chloraepstic spray<br>Quick Strep test | Acetaminophen 650mg po<br>Ibuprofen 400mg po<br>Cepacol lozenges po<br><br>If shows positive, take for medical evaluation | Every 4 hrs PRN<br>Every 4 hrs PRN<br>Every 2 hrs PRN<br><br>PRN | 4 doses daily<br>4 doses daily<br>12 doses daily<br><br>PRN |
| **SUNBURN** | Aloe Vera Gel<br>Solar Caine Spray | As per directions on package<br>As per directions on package | PRN<br>PRN | Per pkg directions<br>Per pkg directions |
| **MOISTURE ABSORPTION RASHES; ITCHING** | Cornstarch Powder | As per directions | PRN | Per pkg directions |

| **Physician's Signature:** | **Date:** |
|---|---|

CAMP LOYALTOWN

## BREAKTHROUGH SEIZURE PROTOCOL ONLY

Dear Doctor, ____________________________________ is attending Camp Loyaltown.

Camp Loyal town has a Health Center staffed with Nurses that can administer as needed medication for break through seizures including Diastat, Midazolm or other rescue seizure medication.

Please detail your desired breakthrough seizure protocol for us to follow:

Medication ____________________________

Dose ____________________________

Route ____________________________

Seizure's Type____________________________

Seizure Diagnosis__________________________________________
Frequency________________________________________________
Duration_________________________________________________
Date of last seizure_________________________________________
When does the camper's parent and or MD need to be notified? ____________________________________
Does the camper have a VNS placement? ____________________________If so, what is the protocol?
___________________________________________________________________

Please describe any other pertinent information (please be specific)
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

MD signature _______________________________________ Date _________________

*Please be aware that the bus/van ride to camp is usually about 3 hours from Long Island. There is no medical staff traveling on the bus/van able to administer medications. Your signature above will suspend the order until the camper arrives at camp; however, in the event of a seizure occurring on the bus/van, Emergency Medical Services will be called via 911.