CAMP LOYALTOWN

INDIVIDUAL'S NAME:

CAMP LOYALTOWN 2023

Dear Parents and Guardians,

Please submit this packet with the required information attached, signed and dated. The medical forms, information and dates must encompass the camper's entire stay at camp during 2023.
DUE ON OR BEFORE MARCH 9th, 2023
*****PLEASE BE ADVISED IF YOUR MEDICAL FORMS ARE NOT SUFFICIENTLY COMPLETED THEY MAY BE RETURNED**. ***

1. ☐ Copy of Specialized Eating/Nutrition Guidelines

   ☐ **Not** Applicable

2. ☐ Copy of Adaptive Equipment Guidelines

   ☐ **Not** Applicable

3. ☐ Specific Medical Guidelines/Protocols; e.g. insulin, bowel (Please send Physician's orders)

   ☐ **Not** Applicable

4. ☐ **ANNUAL PHYSICAL EXAM**
   Camp Loyaltown (or AHRC) 2023 ANNUAL PHYSICAL EXAM (MUST COVER THE INDIVIDUAL FOR THE DAYS THEY ARE ATTENDING CAMP)
   Including Medication orders and treatments prescribed to camper. Physician's orders must include any Prescription Medications, Routine OTC (over the counter), Vitamins, dietary supplements, inhalers, liquids, allergy medications, g-tube feedings etc.
5. ☐ **PRN MEDICATION ADMINISTRATION FORM**
   2023 Camp Authorization for PRN Med Administration Form
6. ☐ **MEDICAL CLEARANCE FORM**
   2023 Medical Clearance form, signed and stamped by physician
7. ☐ **Copy of FULL Immunization Record.**

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, tetanus and varicella. The record must be kept on file for every camper and *updated annually.*

8. ☐ **MENINGOCOCCAL MENNINGITIS VACCINATION RESPONSE FORM-** please check the box as to whether your camper has received the meningitis vaccine; or if not, check the box that reads that you have read the information provided regarding the risks of not receiving the vaccine. Please also sign and date the form.
9. ☐ **CONSENT FOR EMERGENCY OR ROUTINE MEDICAL TREATMENT/MEDICATION ADMINISTRATION-**please fill in your camper's name and sign and date the form to consent.

CAMP LOYALTOWN 2023

This Page Must Be Completed for All Campers (including residential campers)

***MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM**

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

****Check ONE box and sign below****

☐ My child has received meningococcal immunization (Menactra or Menveo) within the past 10 years.
Date received:______________________________

[Note: The Centers for Disease Control and Prevention recommend two doses of MenACWY vaccine (Brand names: Menactra, Menveo) for all adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at 16 years of age. Adolescents in this age group with HIV infection should get three doses: 2 doses at least 8 weeks apart at 11 or 12 years of age, plus a booster dose at 16 years of age. If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18 years of age. If the first dose (or series) is given after the 16th birthday, a booster is not needed. Young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series (Brand names: Trumenba, Bexsero). Parents/guardians should discuss the Meningococcal B vaccine with a healthcare provider.]

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal disease.

PLEASE SIGN BELOW REGARDLESS OF WHETHER YOUR CHILD HAS RECEIVED THE VACCINE OR NOT

Signed: ____ **Date:** ______________________

****CONSENT FOR EMERGENCY OR ROUTINE MEDICAL TREATMENT/MEDICATION ADMINISTRATION***

In the event that (CAMPER NAME) ______________________________ requires emergency medical treatment under Camp Loyal town supervision, and I, the parent or legal guardian cannot be reached, the staff of Camp Loyaltown is hereby authorized to sign for permission for treatment. I hereby give permission to the medical professional selected by Camp Loyal town to hospitalize, secure proper treatment for, and/or order medications, injections, anesthesia and/or surgery for my child/family member, without limitations. I also give permission for the administration of medication and routine medical treatment while at Camp.

Parent/Legal Guardian Signature: _____________________________

Date: ________________________________

Camper name: ---

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

FRONT	BACK
FRONT	BACK

CAMP LOYALTOWN
ANNUAL PHYSICAL EXAM 2023

CAMP OFFICE Phone: (516) 626-1075 ext.1452 (until June 1st)
CAMP OFFICE Fax: (516) 396-9771 (until June 1st)

CAMP Phone: (518) 263-4242 (after June 1st)
CAMP Fax: (518) 263-3911 (after June 1st)

Name_________________________________

Date of Birth: ________________

Date of Exam: ________________

DIAGNOSIS: _________________________

ALLERGY HISTORY

NKDA ☐ ________________________________

Medication Allergy__________________________

Food Allergy ______________________________

Environmental ______________________________

MEDICAL HISTORY

Date of Last Tetanus Shot (month & year)_____________

Medical Issues ____________
____
____

Surgical/Date ______________
____
____
____

Psychiatric Issues ___________
____
____
____

Seizure's Type_____________________

Frequency ________________

Last Seizure___________________

Shunt Present _____________

Shunt Location _____________

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. given in applesauce, etc.
EXAMPLE ONLY Acetaminophen 325mg	2 tabs Twice a day	By mouth	Pain relief	Whole with Water

EMERGENCY MEDICATION PROTOCOLS

(i.e. for Breakthrough seizure: activity or behavioral issues)

Purpose (ie. Seizure Cluster or Behavior)	Medication	Doses, frequency	Route	Special Considerations

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

ANNUAL PHYSICAL EXAM

Name________________________________ Weight ________ Height __________

Vitals BP __________ Pulse ________

Resp _________ Temp ________

Skin:

Head/Neck/Thyroid:

Nose/Throat:

Eyes/Vision: Right Left

Corrective Lenses: ☐ yes ☐no

Ears/Hearing:

Hearing Aids: ☐ yes ☐ no

Dentition:

Dentures : ☐yes ☐no

Neuro/Behavioral:

Seizures: ☐yes ☐no

Cardiac:

EKG Abnormalities:

Chest/Breast Exam:

Mammogram Abnormalities:

Pulmonary:

Abdomen/GI:

Recto/Procto:

Renal/Urinary:

Genitalia/Gynecological:

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:

____

____

____

Physician signature ______________________________

Date: __________

(Print or Stamp)
Physician Name______________________________

Address ____________________________________

Telephone # (   ) _______________________

**Neurological Symptoms of Atlanto Axial Instability: For individuals diagnosed with Down Syndrome in order to participate in the Horseback Riding Program at Camp Loyaltown

Atlanto Dens Interval X-rays : Date ______________ Result **+** **-**

***PLEASE ATTACH copy of the Immunization Record * or complete the following grid on page 9.**

***Bloodwork titers may be acceptable; also, physician documentation that ALL immunizations are up to date is acceptable.**

CAMP LOYALTOWN MEDICAL CLEARANCE – 2023

***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, all 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 grounds
- Health Center is air conditioned
- The doctor we use is located approximately 20 miles 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.___/___/____
(Must check either box)

☐ **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

INDIVIDUAL:	ALLERGIES:	DOB:	DOSAGE: ☐ADULT ☐*CHILD** *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	Hydrogen Peroxide Triple Antibiotic Ointment Bactine spray	Hydrogen Peroxide to wound, wash with soap & water. Apply antibiotic ointment to area and cover with dry dressing. 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 Hydrocol 1% cream	Benadryl 25 mg po Topical to affected area	Every 6 hrs PRN Every 4 hrs PRN	4 doses daily 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 Desenex Powder	Topically to affected area	BID PRN	
BURNS (1st degree) reddened & injured skin <u>without</u> 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 Senna tabs Miralax Powder Glycerin Suppository Fleets Enema	Milk of Magnesia 30 ml po Senna Tabs 2 po 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 Glycerin Supp PR Fleets Enema PR daily PRN	Daily PRN Daily PRN Daily PRN Daily PRN 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) Light diet, banana, rice, toast, tea, and applesauce.	Light diet, (B R A T T Diet) Pepto-Bismol	Light diet until normal bowel movement returns Pepto-Bismol 30 ml po	Each meal daily PRN 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 Ibuprofen	Acetaminophen 650mg po Ibuprofen 400mg po	Every 4 hrs PRN Every 4 hrs PRN	4 doses daily 4 doses daily
GENERAL DISCOMFORT; **HEADACHE** without meningeal signs; **MENSTRUAL CRAMPS**	Acetaminophen Ibuprofen/Motrin	Acetaminophen 650 mg po Ibuprofen/Motrin 400mg po	Every 4 hrs PRN Every 4 hrs PRN	4 doses daily 4 doses daily
GUM, MOUTH SORENESS	Ambusol gel Acetaminophen Ibuprofen	Apply to area of gum soreness Acetaminophen 650 mg po Ibuprofen 400 mg po	Every 4 hrs PRN Every 4 hrs PRN Every 4 hrs PRN	6 times daily 4 doses daily 4 doses daily
INDIGESTION	Pepto-Bismol Antacid tabs Mylanta liquid	Pepto-Bismol 30 ml po Antacid 2 tablets po Mylanta liquid 30 ml po	Between meals and H.S. Every 4 hrs PRN Every 4 hrs PRN	4 doses daily 4 doses daily 4 doses daily
NASAL CONGESTION	Phenylephrine	10 mg po 1 tab	Every 4 hrs PRN	4 doses daily
PUNCTURE WOUND	Hydrogen Peroxide Triple Antibiotic Ointment	Hydrogen Peroxide to wound, wash w/ Soap & water; 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 **SORE THROAT WITH DEEP REDNESS/ PATCHES**	Acetaminophen Ibuprofen Cepacol Lozenges Quick Strep test	Acetaminophen 650mg po Ibuprofen 400mg po Cepacol lozenges po If shows positive, take for Medical eval	Every 4 hrs PRN Every 4 hrs PRN Every 2 hrs PRN PRN	4 doses daily 4 doses daily 12 doses daily PRN
SUNBURN	Aloe Vera Gel Solar Caine Spray	As per directions on package As per directions on package	PRN PRN	Per pkg directions Per pkg directions
MOISTURE ABSORPTION RASHES; ITCHING	Cornstarch Powder	As per directions	PRN	Per pkg directions

Physician's Signature:	**Date:**

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.

Name: ____________________________

Camp Loyaltown 2023

Immunization Record

This is REQUIRED by the New York State Health Department for all campers.

Immunization record which must include immunization dates against:

Diphtheria, Tetanus, Pertussis, Haemophilus influenza type B (HIB), Hepatitis B, Measles, Mumps, Rubella (MMR), Poliomyelitis, Varicella, Tetanus Booster within the last 10 years.

As per Department of Health requirement, Immunization records must be kept on file and updated ANNUALLY.

Please Complete the form below or Attach a copy of full Immunization Record.

Provide the month and year for each immunization.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Booster Month/Year
***Diphtheria, tetanus, pertussis** (DTaP) or (TdaP)						
***Tetanus booster** (dT) or (TdaP)						
***Mumps, measles, rubella** (MMR)						
***Polio** (IPV)						
***Haemophilus influenza type B** (HIB)						
Pneumococcal (PCV)						
***Hepatitis B**						
***Varicella** (Chicken pox)	☐Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:	☐ Negative	☐ Positive			
Additional Immunization Information:						

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

Summer: 118 Glen Ave, Hunter, NY 12442 – (518) 263-4242

Winter : 189 Wheatley Road, Brookville NY 11545 – (516)-626-1000

BREAKTHROUGH SEIZURE PROTOCOL ONLY

Dear Doctor, Date___________

_______________________________________ is attending Camp Loyaltown.

We have a Health Center staffed with Nurses that can administer as needed medication for break through seizures including Diastat.

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

Medication ______________________________

Dose ______________________________

Route ______________________________

Describe Type/Quality/Quantity/Frequency of seizures to be treated. Be as specific as possible.

____

____

____

*Please be aware that the bus/van ride to camp is usually about 3 hours from Long Island. There is no medical staff on the bus/van able to administer medications. This will suspend the order until the camper arrives at camp. In the event of a seizure occurring on the bus/van, Emergency services will be called via 911.

MD signature ____ Date ___________________

Return fax to (518) 263-3911

Request for Religious Exemption to Immunization Form

Parent/Guardian Statement

Name of Camper ____

Name of Parent/Guardian ____

This form is for your use in requesting a religious exemption to Public Health Law immunization requirements for your child. Its purpose is to establish the religious basis for your request since the State permits exemptions on the basis of a sincere religious belief. Philosophical, political, scientific, or sociological objections to immunization do not justify an exemption under Department of Health regulation 10 NYCRR, Section 66-1.3 (d), which requires the submission of:

- **A written and signed statement from the parent, parents, or guardian of such child, stating that the parent, parents, or guardian objects to their child's immunization due to sincere and genuine religious beliefs which prohibit the immunization of their child in which case the principal or person in charge may require supporting documents.**

In the area provided below, please write your statement. The statement must address all of the following elements:

- **Explain in your own words why you are requesting this religious exemption**
- **Describe the religious principles that guide your objection to immunization**
- **Indicate whether you are opposed to all immunizations, and if not, the religious basis that prohibits particular immunizations.**

You may attach to this form additional written pages or other supporting materials if you so choose.

____

____

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____

____

Signature or Parent/Guardian **Date**

REFUSAL TO SIGN PERMISSION TO TREAT FORM

If you, as the camper's parent/legal guardian, refuse to sign a permission to treat form, for religious or other reasons, please specify the action to be taken if the camper needs care or treatment. I ______________________ (parent/guardian) release Camp Loyal town from liability if I cannot be reached in an emergency.

**Parent/Guardian Signature__________________________ Date:_________________________________

Camper Name: _________________________________ Date:__________________________________

Action to be taken if camper needs care or treatment:

____
____
____
____
____
____
____

____

CAMP LOYALTOWN

Supplemental Camp Consent Form

Summer 2023

Please read fully before ticking the box and signing below.

Parent/Guardian Name: ______________________________

Parent Signature: ___________________________________

Camper Name: ____________________________________

Date: ____

☐ I permit my camper to carry and use sunscreen to protect against overexposure to sun

☐ I permit my camper to carry and use insect repellent

☐ I permit camp counselors to assist my camper to apply insect repellent

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Specific information to be released: Entire Medical Record, including histories, notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers. Reason for release of information: **Medical Oversight**. By signing here I authorize any Hospital, Medical office, Laboratory or Diagnostic Imaging center to discuss and release my health information, either verbally, via documents or electronically; with the person or agency listed here: **Camp Loyaltown**. This authorization remains in effect from the summer camp session beginning June of 2022 and covers any respite stays up until the end of May 2023.

X____ (Parent/Guardian/Individual) Date:________________

Sign above or you can go here and create a digital signature and complete/ email those forms https://eforms.com/release/medical- hipaa/

For further information please click or follow the links – 45 C.F.R. Part 160 and 45 C.F.R. Part 164