Latvian Church Camp Health Info / Emergency Contact Form - Page 1 2024

INSTRUCTIONS:

-Page One must be completed and signed by parent/guardian

-Page Two must be completed and signed by a licensed healthcare provider (MD, DO, NP, PA), based on a physical examination performed within 13 months of arrival at camp. *Examination is for determining fitness to engage in strenuous activities. Your HCP's standard health exam form may be substituted for Pg 2.*

Please do not bring a sick child to camp. If camper is discovered to be ill during camp registration they will not be able to start camp until symptom free as per NY DoH guidelines; camper will remain with parents at the camp director's/nurse's discretion.

NAME: Birth date: Age: Sex:

PARENT/GUARDIAN: _____ Home phone: _____ Cell phone: _____

Address: _____ Primary email: _____

If not available, in an emergency notify:

1. Name: _____

Relationship: _____ Home phone: _____ Cell phone: _____

2. Name: _____

Relationship: _____ Home phone: _____ Cell phone: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____

Health insurance co: _____ Policy #: _____ Group #: _____

Dentist: _____ Phone: _____

Orthodontist: _____ Phone: _____

Mental Health Provider: _____ Phone: _____

HEALTH HISTORY (check all that apply; provide approximate dates and/or relevant information in the space provided)

- ☐ Sleepwalking _____
- ☐ Nightmares/Terrors _____
- ☐ Bedwetting _____
- ☐ Constipation _____
- ☐ Nosebleeds _____
- ☐ Glasses _____
- ☐ Contact lenses _____
- ☐ Braces _____
- ☐ Retainer_____
- ☐ Hearing Aids_____
- ☐ Mobility Device_____

Allergies

- ☐ Environmental_____
- ☐ Insects_____
- ☐ Medication _____
- ☐ Food _____
- ☐ Other _____

Has EpiPen perscribed? ☐ Yes ☐ No

Diseases (date)

- ☐ Asthma _____
- ☐ Diabetes _____
- ☐ Heart defect _____
- ☐ Seizures _____
- ☐ Anxiety_____
- ☐ Depression_____
- ☐ History of suicidal ideation

☐ *If applicable* - Has the camper menstruated? _____ If not, have they been told about it? _____

☐ Dietary restrictions _____

☐ Operations or serious illness _____

☐ Broken bones / concussion _____

☐ Activities to be restricted _____

☐ Family situations we should be aware of _____

☐ Other physical or mental diagnoses _____

☐ IEP or 504 accommodations _____

PARENT'S AUTHORIZATION. This health history is correct and complete so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by me and the examining HCP. I hereby consent to the disclosure of information contained on this form to Latvian Church Camp personnel, medical professionals and others as deemed appropriate. I hereby give permission to the HCP selected by the camp director to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I hereby give permission for the HCP selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anaesthesia and/or surgery for my child as named above.

Signature: _____ **Date:** _____

PLEASE NOTE
This page must be completed and signed by a licensed health care provider, based on a physical examination performed within 13 months of arrival at camp. Examination is for determining fitness to engage in strenuous activities.

Your health care provider's standard health exam form may be substituted for this form.

NAME:	Birth date:	Age:	Sex:

PHYSICAL EXAM (Code: V-satisfactory, X- not satisfactory O- not examined) **Date of exam:** _____

Height _____ Weight: _____ Blood pressure: _____

Hct or Hgb Test _____ Urinalysis _____ Lungs _____
Genitalia _____ Abdomen ____ Hernia _____
Throat _____ Extremities _____ Heart _____
Posture _____ Spine _____

Vision _____ RT _____ L_____ ☐ Corrective lenses?

Hearing _____

Allergy (please specify) _____

General appraisal: _____

Recommendations and restrictions

☐ Special diet_____

☐ Current medications_____

☐ Activities to be restricted _____

☐ Other_____

☐ **IMMUNIZATION RECORD ATTACHED**

HEALTH CARE PROVIDER'S (MD, DO, NP, PA) **SIGNATURE**

I have examined the child herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in all camp activities, except as noted above.

Examining HCP: _____ **Phone:** _____

Address: _____

Signature: _____ **Date:** _____

Dear Parent/Guardian:

We would like to inform you of the policies that have been put in place for the health and safety of campers requiring medication administration during camp.

Health Center staff are responsible for administration of all medication. If your child needs a medication, either prescription OR over-the-counter during camp please follow this policy so that we may begin to administer the medication as soon as possible. Thank you in advance for your cooperation.

The Standing Order for Over the Counter and Prescription Medication Form must be completed in ink and be on file in the Health Center before any medication is administered.

- Non-prescription medication (over-the-counter) will be handled the same as prescription medication (including vitamins & dietary supplements).

- All medication must be delivered in a correctly labeled pharmacy, or manufacturer's medication container.

- The pharmacy-labeled container can be used in lieu of a physician's order only in the case of short-term medications, i.e., those medications to be given for ten (10) days or less (e.g. antibiotics). If the Health Center staff has a question about the medication, they may request a licensed prescriber's order.

- Self-medication can be allowed under certain circumstances (e.g. inhalers), after consultation with the Health Center staff. Unless authorized in writing by the Health Office staff, all medications must be kept in the Health Center.

- Epi-Pen - If your child requires an Epi-Pen, please submit two Epi-Pens if possible (to be held in Health Center and Dining Hall). Please submit a photo of your child with each Epi-Pen.

- Inhalers - If your child requires an inhaler, please submit a photo of your child with the inhaler.

- All medications must be picked up by a parent/guardian, before the close of camp. Any medications that are not picked up by close of camp will be destroyed.

Latvian Church Camp / Standing Orders for Over the Counter & Prescription Medications 2024

INSTRUCTIONS:
The New York State Camp Safety Advisory Council requires individualized standing orders for each camper for the camp's health care staff to follow in administering both over the counter medications and prescription medications. **Please complete no more than 6 months prior to the start of camp.**

NAME:	**Birth date:**	**Age:**	**Sex:**	**Weight:**

Parent or Guardian:
Please check the box if OK to administer per label. Must be signed by physician below.

- ☐ Benadryl
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Tylenol (Acetaminophen)
- ☐ Sudafed (Tablets or Children's Elixir)
- ☐ Throat Lozenges/Cough Drops
- ☐ Musinex (Tablets or Children's Liquid)
- ☐ Pepto Bismol
- ☐ Tums
- ☐ Neosporin Ointment
- ☐ Mediquick Spray
- ☐ Hydrocortisone (1% cream)
- ☐ Aloe or Burn Spray
- ☐ Calamine Lotion
- ☐ Swimmer's Ear drops
- ☐ Lice Shampoo
- ☐ Delsym (12 Hour Cough Relief)
- ☐ Children's Robitussin DM
- ☐ Orajel
- ☐ Robitussin

Health Care Provider: List any additional over the counter medications (including vitamins) and/or prescription medications as ordered that the camper will be taking on an as needed or daily basis. All medication must be in the original labeled container and handed to the Health Center staff during check-in. These medications will be kept in the Health Center during the camper's entire stay.

Medication	Dosage	Route	Time of Day

Health Care Provider's (MD, DO, NP, PA) **Signature:** _____

Health Care Provider's Name: _____

Office Phone: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Latvian Church Camp

MENINGOCOCCAL VACCINATION RESPONSE FORM

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

Check one box and sign below.

☐ My child has had the meningococcal meningitis immunization* within the past 10 years.
Date received: _____

[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

☐ 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 meningitis disease.

Signed: _____ Date: _____
(Parent/Guardian)

Camper's Name: _____ Date of Birth: _____

Mailing Address: _____

Parent/Guardian's E-mail address (optional): _____

*May be listed on the immunization record as any of the following: Meningococcal (conjugate), MenVeo, Menactra, MCV4(P), Men ACWY, Meningitis

Rev. 2021

Latvian Lutheran Camp
231 Green Hill Rd.
Elka Park, NY 12427

Date: _____

I give my child,
_____,

permission to use sunscreen and insect repellent as needed while at camp.

_____ _____
Parent/guardian name Parent/Guardian signature

Latvian Lutheran Church Camp

Children's Camp COVID-19 Testing Consent Form

Children's Camp Operators must obtain parental consent to administer or obtain COVID-19 testing for a camper. There are two kinds of tests for COVID-19: the PCR test and the antigen test (also known as a rapid test). Both tests require a specimen (sample) be collected (taken) from the person being tested. The sample is then tested to find out if the person has COVID-19. How a sample is collected depends on the type of test being used.

Only campers whose parents/guardians have signed this consent form will be tested.

COVID-19 Testing will be done at:

☐ Our camp

_____

The following type of sample will be collected:

☐ Nasal Swab (front/sides of nose) collected by trained healthcare personnel

To be Completed by Parent/Guardian

Camper's Name: DOB:

Address: Date:

I give permission to: Latvian Lutheran Camp

☐ **Collect a sample from my child and test for COVID-19.**

I understand the camp will notify me if my child's test is negative by a letter, email, or phone call.

If my child's test is positive for COVID-19, I will be notified by phone call.

I understand that my child's test results and other information may be disclosed as permitted by law.

Parent/Guardian Name: Phone: _____

Signature: Date:

Please return this signed form to the children's camp.