

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: _____
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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 _____ <input type="checkbox"/> Glasses _____ <i>Allergies</i>		<i>Diseases (date)</i>
<input type="checkbox"/> Nightmares/Terrors _____ <input type="checkbox"/> Contact lenses _____ <input type="checkbox"/> Environmental _____		<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Bedwetting _____ <input type="checkbox"/> Braces _____ <input type="checkbox"/> Insects _____		<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Constipation _____ <input type="checkbox"/> Retainer _____ <input type="checkbox"/> Medication _____		<input type="checkbox"/> Heart defect _____
<input type="checkbox"/> Nosebleeds _____ <input type="checkbox"/> Hearing Aids _____ <input type="checkbox"/> Food _____		<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Mobility Device _____ <input type="checkbox"/> Other _____		<input type="checkbox"/> Anxiety _____
	Has EpiPen perscribed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Depression _____
		<input type="checkbox"/> 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: _____
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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 _____

<input type="checkbox"/> IMMUNIZATION RECORD ATTACHED
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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.

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

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

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

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: <u>Latvian Lutheran Camp</u>	
<input type="checkbox"/> 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.