

Checklist for Camper Acceptance Packet

Please complete the following forms included in this packet:

- Daily Living Skills
- General Medical Information
- Medication Record
- Permission to Treat Form
- Transportation & Permission Form
- Camper Specific PRN Orders *[Needs to be printed and completed by a physician]*
- Dietary Nutrition Orders *[Needs to be printed and completed by a physician]*
- Physical Exam - *A blank copy of our medical is included but you can alternatively provide a copy of a physical that you already have as long as it is dated within one year of the campers stay at camp and signed by your physician*
- Meningococcal Meningitis Vaccination Response Form (only for 13-21yrs)

Also include the following with your acceptance packet:

- Copy of Medicare card and Medicare Part D card if this applicant has Medicare
- Copy of Medicaid card, if this applicant has Medicaid
- Copy of private insurance card, if this applicant has private insurance
- 3 current photos
- Current Psychological
- Current Psychosocial
- Current Behavior Plan (If applicable)

Applicant's Name _____

Daily Living Skills 2011

Your answers will assist us in providing a safe and enjoyable vacation experience

Communications

- Uses speech, full and/or short sentences
- Clear, single words
- Difficult to understand
- Attempts words, unclear
- Non Verbal

If non-verbal:

- Uses sign language
- Uses gestures
- Has communication board, other device or pictures
- Does not outwardly appear to communicate

Activity Level

- Initiates own activities, shares interests with others
- Very active, at times impulsive
- Requires occasional encouragement to complete activity

- Does not initiate activities however participates with continual encouragement and/or supervision
- Does not willingly participate in most activities

Comprehension

- Understands most conversations
- Understands most directions

- Limited understanding of conversations/ directions
- Does not outwardly respond

Interests

- Dance
- Acting
- Music
- Drawing
- Cooking
- Writing
- Photography
- Basketball
- Soccer
- Pool
- Boating
- Horses
- Gardening
- Animal Care
- Running
- Reading
- Singing
- Other: _____

Favorite leisure activity is _____

While on vacation applicant is most looking forward to: _____

Does applicant have any known fears? If so, please explain

Socialization

- Enjoys activities with others
 - Accepts limited contact with others
 - Prefers solo activities
- Engages in behavior that can be harmful to self or others
- Rarely Often Never
- Please explain : _____
- _____

Applicant is currently working toward goals outlined in a behavioral plan.

- Yes no

NOTE: To ensure quick response regarding your application, please provide a copy of the behavior plan when you return this application.

Bathing and Showering

- Independent, no assistance
- Requires verbal prompting, reminders

- Hand over hand physical assistance required
- Total assistance required with all bathing tasks

Applicant Name: _____

Mobility	
<input type="checkbox"/> Walks independently <input type="checkbox"/> Requires occasional physical assistance walking over uneven ground, upstairs and over difficult terrain <input type="checkbox"/> Utilizes cane or walker (please circle which) <input type="checkbox"/> Requires direct physical assistance of one person while walking at all times <input type="checkbox"/> Uses splint for wrist/arm <input type="checkbox"/> AFOs <input type="checkbox"/> Scoliosis vest	For participants who use a wheelchair: <input type="checkbox"/> Wheelchair for long distances only <input type="checkbox"/> Wheelchair at all times (<input type="checkbox"/> Manual <input type="checkbox"/> Electric) During transport to camp: <input type="checkbox"/> Must remain in wheelchair for the duration of 2-3 hour trip <input type="checkbox"/> Can transfer to a seat on the bus –able to sit independently <input type="checkbox"/> Can transfer to a seat on the bus - needs staff by their side
Dining Room Skills	
<input type="checkbox"/> Uses fork, knife and spoon <input type="checkbox"/> Uses fork and spoon only <input type="checkbox"/> Requires adaptive spoon or fork <input type="checkbox"/> Requires plate guard <input type="checkbox"/> Assistance to drink hot/cold liquids from cup/ glass <input type="checkbox"/> Drinks liquids from adaptive cup with no assistance <input type="checkbox"/> No known risks for choking <input type="checkbox"/> Needs constant supervision while eating	<input type="checkbox"/> Wears dentures <input type="checkbox"/> Eats rapidly <input type="checkbox"/> Difficulty with chewing <input type="checkbox"/> May “stuff” food Generally appetite is: <input type="checkbox"/> Fair <input type="checkbox"/> Average <input type="checkbox"/> Excessive Favorite foods include: _____ _____ _____
Toileting Skills	
<input type="checkbox"/> Uses toilet independently <input type="checkbox"/> Requires supervision on toilet Requires incontinence pads <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Both <input type="checkbox"/> Uses words or other method to indicate need. Explain: _____ _____	(Female only) <input type="checkbox"/> Independent with menstrual care <input type="checkbox"/> Some assistance required with menstrual care <input type="checkbox"/> Total assistance needed with menstrual care
Dressing	
<input type="checkbox"/> Independent, no assistance <input type="checkbox"/> Requires verbal prompting, assist with appropriate clothing selection	<input type="checkbox"/> Physical support needed with buttons, zippers, tying shoes <input type="checkbox"/> Total assistance required with all tasks
Sleeping Habits and Routines	
Usually goes to sleep at _____ PM Usually wakes at _____ AM Difficulty sleeping at night <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Always Gets out of bed during the night <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Requires repositioning throughout night Explain: _____ _____	<input type="checkbox"/> Requires bed rails at night (<i>Script required for bed rails</i>) <input type="checkbox"/> Requires hospital bed <input type="checkbox"/> Wears diapers at night Requires special equipment to maintain position and prevent skin breakdown <input type="checkbox"/> Straps <input type="checkbox"/> Egg Crate <input type="checkbox"/> Pillows <input type="checkbox"/> Wedges <input type="checkbox"/> Cushions <input type="checkbox"/> Bolsters If individual has difficulty sleeping, the usual intervention is to: _____ _____

General Medical Information – 2011

	CONDITION	YES	NO	EXPLAIN
1	ALLERGIES	<input type="checkbox"/> yes	<input type="checkbox"/> no	
2	BREATHING PROBLEMS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
3	HEART PROBLEMS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
4	STOMACH OR DIGESTIVE PROBLEMS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
5	URINARY TRACT PROBLEMS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
6	INCONTINENCY- URINE OR STOOL	<input type="checkbox"/> yes	<input type="checkbox"/> no	
7	CHEWING /SWALLOWING PROBLEMS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
8	CHANGE IN DIET	<input type="checkbox"/> yes	<input type="checkbox"/> no	
9	CONSTIPATION	<input type="checkbox"/> yes	<input type="checkbox"/> no	
10	SEIZURE DISORDER	<input type="checkbox"/> yes	<input type="checkbox"/> no	
11	OTHER NEUROLOGICAL	<input type="checkbox"/> yes	<input type="checkbox"/> no	
12	DIABETES	<input type="checkbox"/> yes	<input type="checkbox"/> no	
13	HEARING OR VISION PROBLEMS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
14	OSTEOPOROSIS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
15	SKIN CONDITIONS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
16	PSYCHIATRIC ISSUES	<input type="checkbox"/> yes	<input type="checkbox"/> no	
17	BLOOD DISORDERS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
18	HISTORY OF FALLS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
19	INJURIES	<input type="checkbox"/> yes	<input type="checkbox"/> no	
20	HOSPITALIZATIONS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
21	ER VISITS	<input type="checkbox"/> yes	<input type="checkbox"/> no	
22	ANY OTHER ILLNESS	<input type="checkbox"/> yes	<input type="checkbox"/> no	

Person Completing Form: _____

Sign: _____ Date: _____

Camp Application Addendum
MEDICATION RECORD 2011

Camper/Guest Name: _____

Date of Birth: _____

Allergies: _____

Does the camper take Medication? Yes No

If Yes complete this form (additional space on the bottom if needed)

If No, go no further

Please note: A doctor's order is required for all over the counter (including vitamins and herbal preparations) and prescription medications to include any topical creams or powders. A doctor's order may be in the form of a copy of the original prescription, a letter on the doctor's stationery listing the medications and signed by the doctor, or the doctor can sign and stamp this completed form. Original prescriptions will not be accepted or filled at camp.

If medications change from now until the camper goes to camp, the changes must be communicated to camp in the form of a new doctor's order following the above guidelines. These changes can be faxed to Camp Anne at 518-329-6050 or to the Lodge at 518-589-0100

How does the camper take his or her medication?

Whole, swallows with liquid Crushed Liquid medication only

If crushed, what does the camper mix medication with?

Applesauce Pudding Other: _____

Please list all current medications:

1	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration
2	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration
3	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration

4	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration
5	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration
6	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration
7	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration
8	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration
9	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration
10	Medication Name	Name of Physician who ordered medication
	Dosage and number of pills/ml	Times of Administration

Permission to Treat Form 2011 (To be completed by Parent/Caregiver)

I, the undersigned parent/guardian of _____ (“Camper”), do hereby authorize a Licensed Health Professional from Camp Anne/The Lodge as my agent to consent to any examination, diagnostic tests and procedures, medical treatment, administration of medications, or other care (collectively “Health Care Services”) for any emergency or non-emergency medical needs which are deemed necessary or advisable by, and are to be rendered to the camper under the supervision of, any licensed physician at Sharon Hospital/Kingston Hospital, when such Health Care Services are rendered at said hospital. I agree that neither Camp Anne/The Lodge nor AHRC assume any responsibility for any injury or damage which might arise out of or in connection with any such authorized medical treatment provided by Sharon Hospital or Kingston Hospital. Should Camper require emergency medical treatment, Camp Anne or The Lodge shall promptly report the situation to me.

I further consent to the provision of non-emergency Health Care Services to Camper by licensed health professionals employed by Camp Anne/The Lodge which are deemed necessary or advisable by such licensed health professionals.

This authorization is given in advance of any specific need for treatment.

I authorize Camp Anne/The Lodge and AHRC to release to third parties who are or may be financially liable for Health Care Services provided to Camper, information needed for processing all related claims. I will assume full responsibility for payment of medical expenses not covered by insurance.

This authorization shall remain effective until Sept 1, 2011, unless sooner revoked in writing delivered to said agent.

Incident Notification

As a matter of policy, the camp administrative nurse will call you whenever an incident involving injury occurs. Camp administration will call you when serious behavior, without injury, occurs. However, the camp experience involves being outdoors and being very active, so minor mishaps such as scrapes, bumps, bruises, and insect bites can occur. We will not call you with such minor events unless you indicate below that you wish to be contacted with each minor occurrence. If you would like to be notified whenever a very minor situation occurs (not involving injury) please check the appropriate box below and sign.

() Yes, call me with every minor occurrence

() No, please do not call me about minor occurrences

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

Transportation & Permission Form 2011

(To be completed by Parent/Guardian)

Name of Camper: _____

Please place an check the appropriate boxes:

- Reserve a space on the bus for transport to camp
- Reserve a space on the bus returning to New York City (last day of camp)
- Do NOT reserve a space on bus to camp. I will arrange transportation to the camp.
- Do NOT reserve a space on bus to New York City (last day of camp). I will arrange transportation home

Please choose a registration/pick-up and drop off location:

- Manhattan – at 140 West 62nd Street between Columbus and Amsterdam Avenues, it is right near Lincoln Center & Fordham Law School)
- Queens (**CAMP ANNE ONLY**) - location is in a park next to the Ramada Inn at 37-10 114th Street between 37th and 38th Avenue, Corona
You must stay with the camper until they are checked in and board the bus

Waterfront/Horseback Riding Permissions

Permission to swim at the pool yes no Signed _____

Permission to ride on the pontoon boat yes no Signed _____

Permission to ride on the paddle boat yes no Signed _____

It is understood that a qualified lifeguard will be on duty at all times the waterfront area is open, and at Camp Anne all participants will be wearing a life jacket.

Permission to horseback ride yes no Signed _____

All participants will wear helmets and protective jackets and be supervised by at least two staff

Record Release

Do we have your permission to request information from any school, training program, clinic, or employment that the applicant is now attending? yes no Signed _____

Completed by: _____ Title: _____

Date: _____

CAMPER SPECIFIC PRN ORDERS 2011

Camper/Guest Name: _____ Date of Birth: _____

Diagnosis: _____

Allergies: _____

The following may be used for 48 hours and/or one episode x5 doses, then consult MD for further orders.
Medications to be given po unless otherwise indicated.

PHYSICIAN MUST INDICATE WITH A "V" WHICH ORDERS APPLY:

- Ibuprofen 200mg two tablets po q4h prn for pain, headache or fever above 101.
OR
- Acetaminophen 650mg po or suppository q4h prn for pain, headache or fever above 101
- Robitussin DM 5cc po q4h prn for cough with cold symptoms
- Diaper Rash Cream apply thin layer to red areas on perianal area prn and after each diaper change.
- Milk of Magnesia 30cc at hour of sleep prn for constipation
- Mylanta 30cc po q4h prn for complaints of gastric upset
- Fleet enema one per rectum prn if no BM x 3days, may repeat x1
- Dulcolax suppository 10mg per rectum prn for no BM x3days, may repeat x1
- Bacitracin ointment for minor cuts or skin abrasions
- Benadryl 25mg tab or 12.5mg per 5ml, give 10ml tid prn for rash or persistent itch
- Benadryl/Caladryl lotion sparingly to area of bug bite, rash or minor skin irritation tid prn
- Kaopectate suspension 600mg/15ml, give 30cc po after each loose BM not to exceed 4grams 24 hrs
- Imodium 2mg give 2 tabs after first loose BM then 1 tab after subsequent BMs up to 4 tabs in 24 hours
- Loratadine 10mg 1 tab po daily for symptoms of allergy

Physician Signature _____ Date _____

If No PRN orders are applicable, please sign below

Physician Signature _____ Date _____

Dietary Nutrition Orders 2011

Name: _____

Diet Order: _____

Food Consistency – Check one below

Whole – Food is served as it is normally prepared. For those who need assistance cutting food, staff will cut food into ¾” easy to chew pieces. Sandwiches and bread should be served halved or quartered.

Modified Diets

NOTE: The following food textures are not appropriate for a Bite-size, Chopped, Ground or Puree diet: Hard, crunchy, tough, raw veggies, dry, stringy. All foods in these categories MUST be moistened.

Puree – All foods are moistened and blended until smooth to an applesauce-like or custard consistency with NO lumps and is NOT runny. Spoon should not stand up in the bowl nor be pasty.

Ground – Food is put through a food processor until it is in rice sized pieces in a cohesive mass, like rice pudding. Food must be moistened. Loosed dry particles are not acceptable. Breads and sandwich fillings may be moistened and processed to meet this definition.

Chopped – All food is cut or chopped into 1/4 “pieces, about the size of a pea. Sandwiches must have a moist ground filling and such as tuna or egg salad, and be cut into 32 pieces.

Bite Size – Food is served as prepared and cut by staff into ½” pieces, about the size of a cheerio. Sliced bread or sandwiches are cut into 16 roughly equivalent pieces. Cork shapes or foods with sharp or pointed edges are to be avoided.

Other individual considerations: _____

- Beverages – Straws are not to be used for thickened liquids
 - Thin liquids – Liquids are served as usual
 - Netcar/Syrup – Slightly thickened, pours like syrup
 - Honey – Thicker than a syrup consistency, it moves slowly but still pours
 - Pudding – mounds or ploppable at room temperature. Requires a spoon for feeding.

Amount to sip at a time single sip 2,3,4 consecutive sips spoon feed

Physician Name: _____

Physician Signature: _____ Date: _____

TO BE COMPLETED BY A PHYSICIAN



83 Maiden Lane, New York, NY10038
(212) 780-2525

PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ Phone Number: (_____) _____

Medical History/Interval Changes: _____

HT: _____ WGT: _____ BP: _____ Pulse _____ Resp: _____

Allergies: _____ Special Diet: _____

Skin: _____

Head/Neck: _____ Dysphagia: Yes _____ No _____

ENT/Dentition: _____

Eyes: _____ Vision: _____

Ears: _____ Hearing: _____

Chest: _____ Breasts: _____

Lungs: _____

Heart: _____

Abdomen: _____

Genito-Urinary: _____

Rectal: _____

Extremities/Back: _____

Musculo-Skeletal: _____

Neurological: _____

Seizures (Type/Frequency): _____

Mental Status: _____

Medical Diagnosis: _____

TO BE COMPLETED BY A PHYSICIAN

MEDICATIONS	

Limitations/Restrictions/Precautions:

To any physical activity: _____

To any strenuous activity: _____

To environmental agents: _____

SBE precautions: _____

Immunizations:

PPD Mantoux (Mandatory annually)

Date Administered: _____ Date Read: _____ Size of Reaction in mm: _____

Chest X-Ray (if PPD+) Date: _____ Results: _____

INH Therapy indicated: Yes: _____ No: _____

If INH Therapy was administered in past, please indicate dates: _____

Date of last tetanus (required every 10 years): _____

MMR Immune status: _____ Date of Immune Booster: _____

Hepatitis B Immunization Dates: 1) _____ 2) _____ 3) _____

Lab Tests:

CBC	Urinalysis	SMAC-12
Hep B profile	RPR	PSA (over 40 years of age)

C-Spine X-Ray for suspected sub-luxation if participant has Down's Syndrome

Recommendations/Follow Up: _____

Mammogram: _____ PAP: _____ EKG: _____ EEG: _____

Date: _____ Name of M.D. (Please print) _____

Hospital/Clinic Address: _____

Telephone: (_____) _____ M.D. Signature: _____

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

(To be completed by parent/caregiver for children 13-21yrs)

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 (Menomune™) 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): _____