Camp Good Days and Special Times, Inc.

www.campgooddays.org

2022 Camper Health Forms

NEED ASSISTANCE?
Contact Your Regional Office.

Buffalo	716-206-0709
Rochester/ Syracuse	585-624-5555

Camper's First Name:_____ Last Name:_____

Gender: _____ Age:_____ Date of Birth:_____

Address:_____ Primary Phone: (_____)_____

City:_____State:_____ Secondary Phone:(_____)_____

Zip Code:_____ Country: _____ **Must List 2 Valid Phone Numbers**

2022 SUMMER CAMP –Select the Camp Session(s) you/your child will be attending

- ☐ **Camp B&ST: July 25-28, 2022**
- ☐ **Doing A World of Good: August 1-5, 2022**
- ☐ **Childhood USA:August 8-11, 2022 Camp**
- ☐ **SIBS: August 15-18, 2022**

FAMILY CONTACT(S) – To Be Completed by Parent or Guardian

Primary Contact's Name: _____

Relationship to Camper: _____

Phone:_____

Street Address (if different from camper):

_____

State:_____ Zip Code:_____

Secondary Contact's Name: _____

Relationship to Camper: _____

Phone:_____

Street Address (if different from camper):

_____

State:_____ Zip Code:_____

EMERGENCY CONTACT(S) – Person to be contacted in case of an emergency ONLY IF PARENT(S) CANNOT BE REACHED

Name: _____

Relationship to Camper:_____Phone: _____

HEALTHCARE PROVIDER

Institution/ hospital where you receive care:
Phone:

Name of Physician/ Nurse Practitioner:

MEDICAL INSURANCE- Your child must have insurance to attend Camp.

Name of Insurance Company:
Policy Number:_____
Name of Policy Holder:
Date of Birth:

Please attach a copy of both sides of the card, so the information is readable.

Name of Camper:_____

CAMPER INFORMATION

The questions below are important to help support your child's transition into our Camp community.
The information on this page is shared with your child's counselors.
This form needs to be filled out by a PARENT or GUARDIAN.

Has child ever slept away from home? YES ☐ NO ☐

Has your child previously attended Camp Good Days and Special Times? YES ☐ NO ☐

How does your child feel about going to Camp?

Resistant ☐	Nervous ☐	Neutral ☐	Excited ☐	Can't Wait! ☐

Does your child need assistance or supervision with the following? (Check all that apply)

Not Applicable ☐	Brushing Teeth ☐	Combing Hair ☐	Dressing ☐	Bathing/ Showering ☐	Toileting ☐

Bedtime:(Check all that apply)

Not Applicable ☐	Fear of Dark ☐	Nightmares ☐	Night Terrors ☐	Difficulty Waking ☐	Difficulty Falling Asleep ☐	Bedwetting ☐

Other _____

Please describe your child's eating habits:

Eats everything ☐	Tends to skip a meal each day ☐	Needs to be encouraged to eat ☐	Picky Eater ☐

Other _____

Does your child have any dietary restrictions and/or special food requirements?

_____

_____

Has your child experienced any stressful life events in the past year (i.e., death of a family member, friend or pet, divorce, marriage, moving)? ☐ YES ☐ NO

If yes, please describe _____

Is there anything else you would like your child's Camp Counselor to know? Please describe

_____

_____

Name of Camper:_____

CAMPER HEALTH HISTORY – TO BE FILLED OUT BY A PARENT/ GUARDIAN

FOR ONCOLOGY PATIENTS ONLY:

Diagnosis:_____ **Date of Diagnosis:** _____

Currently on Treatment: YES or NO (circle one) **If Yes, when was treatment completed:** _____

Has your child relapsed? YES or NO (circle one) **If yes, date of relapse:** _____

Does your child have a PORTACATH/ BROVIAC/ PICC (check one)? ☐ YES ☐ NO

Will your child need flushes/dressing changes? YES ☐ NO ☐

Does your child have any of the following?

IV ACCESS ☐ SHUNT ☐ FEEDING TUBE ☐ WALKER ☐

WHEELCHAIR ☐ PROSTHESIS ☐ OTHER ☐ _____

Check the days dressing changes are due (if applicable):

SU ☐	M ☐	TU ☐	W ☐	TH ☐	F ☐	SA ☐

Check the days heparin flushes are due (if applicable):

SU ☐	M ☐	TU ☐	W ☐	TH ☐	F ☐	SA ☐

Strength of heparin? 10u/ml ☐ 100u/ml ☐ Other:_____

How much heparin?____cc **How much saline?**____cc

FOR SICKLE CELL ANEMIA PATIENTS ONLY:

Has your child ever been hospitalized for a sickle cell crisis? ☐ NO ☐ YES

If yes, what is the date of the most recent hospitalization?

Is your child on pain medications? ☐ NO ☐ YES

Please list:

Name of Camper:_____

FOR ALL CAMPERS

HEALTH HISTORY: Please describe and give approximate dates if known. If not applicable, please check

YES ☐ NO ☐ **Asthma**

YES ☐ NO ☐ **Cardiac Problems**

YES ☐ NO ☐ **Diabetes**

YES ☐ NO ☐ **Hearing/ Vision Difficulties**

YES ☐ NO ☐ **Neurological Deficit/ Muscular Problems**

YES ☐ NO ☐ **Convulsions/Seizures (type & frequency)**

OTHER_____

ALLERGIES

Allergies to Medications Please list:_____

_____

Allergies to Food Please list: _____

_____

Allergies to Insects Please list: _____

Does the child have permission to swim in the lake? YES ☐ NO ☐

Does the child have permission to swim in a chlorinated pool? YES ☐ NO ☐

Does the child have permission to shower? YES ☐ NO ☐

Recent operations or serious injuries:

_____

Describe any physical disability or physical limitations:

_____

Does your child use any special equipment such as a wheelchair, prosthesis, crutches, walker, or shower chair?

NO ☐ YES ☐ If yes, please describe: _____

If female, has child begun her menstrual period? ☐ NO ☐ YES

BEHAVIOR: Check any behavioral or emotional conditions your child has been diagnosed with

To Be Completed by Parent or Guardian

Not Applicable		ADD		Anxiety		Bipolar Disorder	Autism	
Bipolar Disorder		ADHD		Depression		PTSD	OTHER	

If yes, has medication been prescribed? NO ☐ YES ☐

If so, please list medication(s):

_____

Will your child be taking these medications during the week of Camp? NO ☐ YES ☐

If not, why? _____

Does your child have any communication skill limitations? NO ☐ YES ☐

If yes, please explain _____

Does your camper exhibit any social, emotional, or behavioral issues /concerns: NO ☐ YES ☐

If yes, please explain triggers, cues, redirection, and any helpful hints for volunteers and staff:

_____

_____

_____

Camper Name:_____ **DOB:**_____

STANDARD OVER THE COUNTER/ PRN MEDICATIONS- *PROVIDER SIGNATURE REQUIRED*

(Meds available in the Infirmary/ First Aid Kit; to be administered at the discretion of the RN/ PNP

THIS SECTION MUST BE COMPLETED EVEN IF THE CHILD IS NOT ON ANY MEDICATIONS; PLEASE CIRCLE "YES" or "NO" IN THE PROVIDER ORDER COLUMN AND PROVIDER SIGN BELOW

*This needs to be signed by MD/NP or your child will NOT be able to receive these medications at Camp (just like in schools).

DRUG	ROUTE {please circle preferred formulation(s)}	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Tylenol	PO (chewable tabs, elixir, or tabs)	Per label instructions by age / weight	Q 4 hr prn for pain or fever > □	Yes / No	
Ibuprofen	PO (chewable tabs, suspension, or tabs)	Per label instructions by age / weight	Q 6 hr prn for pain or fever >_____	Yes / No	
Robitussin	PO (syrup)	Per label instructions by age / weight	Q 4 hr prn for cough	Yes / No	
Pepto-Bismol	PO (liquid, or chewable tabs)	Per label instructions by age / weight	Q 30 min to 1 hour prn for diarrhea (no>8 doses/24 hr)	Yes / No	
Dimetapp	PO (elixir or tabs)	Per label instructions by age / weight	Q 6 - 8 hr prn for nasal congestion / drainage	Yes / No	
Benadryl	PO or Topical (elixir, chewables, pills or topical)	Per label instructions by age / weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes / No	
Lotions or Spray (Neosporin, Calamine, Hydrocortisone, etc)		Per label		Yes / No	
Eye Drops		Per label		Yes / No	
Cough Drops		Per label		Yes / No	

Signatures Required:

Provider Name (Print):_____ Date: _____

Provider Signature:_____ Institute/ Hospital: _____

License #: _____

Parent Name (Print):_____ Phone Number:_____

Parent Signature: _____ Date: _____

Camper Name:_____

Rochester Phone: (585) 624-5555 Fax:(585) 624-5799
Syracuse Phone: (315) 434-9477 Fax:(315) 434-9590
Buffalo Phone: (716) 206-0709 Fax:(716) 206-0712

ALL PRESCRIPTION Medications and Additional Over the Counter Medications
PROVIDER SIGNATURE REQUIRED

Nurses will use this form to review protocols and ensure that all medications and proper administration procedures are followed at Camp.

Please complete with patient's current regimen for both **scheduled and prn medications,** including heparin flushes for central lines). **Please include any medication your child routinely takes, including vitamins and natural remedies**; if applicable, include any inhalers used for asthma; PARENTS, please note that you are responsible for sending these medications to Camp with your child.

☐ Child Takes **NO** Prescribed/ Additional Over the Counter Medications

Drug Name	Dose (mgs)	Time taken	Reason	Parent Initial	MD/NP Initials

Additional Orders (as deemed necessary by a health care provider to be implemented by an RN/NP (i.e., blood draws / lab work; dressing changes, cast care; feeds via GT, etc.)

_____

_____

Signatures Required:

Provider Name (Print):_____ Date: _____

Provider Signature:_____ Institute/ Hospital: _____

License #: _____ Phone #: _____

NOTE: Camp Good Days medical staff will call if there are any questions/discrepancies when they are preparing meds to clarify or if you have not sent something to Camp that is listed on their meds forms (use Late changes form)

HEALTH INFORMATION/ PHYSICAL EXAM

(You may send a copy of the immunization and physical from MD's office)

PROVIDER SIGNATURE REQUIRED

VACCINES	Date		Date		Date		Date	
Varicella	#1		#2		Chicken Pox Disease:			
MMR	#1		#2		Measles Disease:			
DTaP	#1		#2		#3		#4	
Tdap	#1		#2		Dose #2 = 21yo booster			
Meningococcal (Menactra, Menveo, MCV4, MecACWY)	#1		#2		#3		Dose #2 = 16yo booster Dose #3 = 21yo booster	
Polio	#1		#2		#3		#4	
COVID-19 (please attach card) ❍ Pfizer ❍Moderna ❍J&J	#1		#2		#3		Dose #3 = booster	
VACCINES	**Date**		**Date**		**Date**		**Date**	
Hepatitis A	#1		#2					
Hepatitis B	#1		#2		#3			
HIB	#1		#2		#3		#4	
Pneumococcal	#1		#2		#3		#4	

Height		Weight	
Vitals (T, P, R, BP)		General Development	
H.E.E.N.T		Skin	
Heart		Lunch	
H.E.E.N.T		GU	
Lymph		Abdomen	
Lung		Musculo-skeletal	
Lymph		Neurologic	

SIGNIFICANT MEDICAL HISTORY:

Medical Conditions/Concerns (i.e., asthma, diabetes, seizure, etc.)

Allergies (medication, food, or insects): ☐ NO ☐ YES Explain:

Food Restrictions: ☐ NO ☐ YES Explain:

Physical Restrictions or Limitations (cast/splinted limb, vision/hearing deficits, mobility issues, etc.):

Signature Required

Provider Name (Print): Date:

Provider Signature:

Name of Camper:_____

CAMPER EXPECTATIONS

In order for Camp to be safe, fun and enjoyable for everyone, there are expectations of how Campers behave in our community. To further illustrate our expectations of our Campers, we have provided a sample list below that includes but is not limited to:

Contributing to an emotionally safe environment

- Each Camper must treat everyone with respect and consideration.
- Camp will not tolerate intimidation, verbal or physical abuse, or destruction of property.
- Cussing, swearing and foul language is not necessary or acceptable at Camp. This includes on clothing and on personal belongings.
- Physical, sexual or suggestive behavior is not appropriate or acceptable at Camp.
- Camp is an experience in group living. For Camp to run successfully, everyone must cooperate by following cabin rules.

Contributing to a physically safe environment

- Cooperate and help out with daily chores (cabin clean-up, activity clean-up, packing and unloading).
- Alcoholic beverages, illegal drugs, vaping, smoking and/or tobacco products are not permitted at Camp.
- Guns, knives, slingshots, fireworks and weapons are not permitted at Camp.

Respecting Camp facilities and equipment

- Camp equipment must be used appropriately.
- Drawing or writing on Camp facilities such as bunk beds, carpet, and bathroom walls is unacceptable.

Unplugged Community

- Camp has a “leave your electronics at the gate” policy for Campers and volunteers.
- Campers are asked not to use their electronic devices at Camp. This includes but is not limited to: Cell Phones, PSP, smart watches, iTouch, DVD players, camcorders and laptops.
- Campers are not allowed to use their cell phones to tell time or as a camera.
- If electronic devices are discovered, we will collect them and return them to the Camper at the end of the session.

If at any time during Camp these expectations are not met, or the Camp Director feels that a Camper's behavior takes away from a positive camping experience, the parent(s) or guardian(s) will be notified and will be required to pick up their child from Camp immediately at their own expense. We have read, discussed and understand the Camper Expectations.

Parent/Guardian Signature: _____ Date _____

CAMPER PERMISSIONS

I. CONSENT FOR MEDICAL TREATMENT:

I hereby grant permission to the medical staff at the Camp or consulting physicians/nurse practitioners to administer routine and any emergency care required to myself in the event of an emergency.

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for myself in the event of an emergency. In the event of an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment to myself, including hospitalization.

_____ _____

Parent/Guardian Signature Date

II. PERMISSION SLIP:

I hereby grant permission to participate in the 2022 Camp Good Days and Special Times, Inc. camping program.

_____ _____

Parent/Guardian Signature Date

III. WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT:

I hereby release, waive, discharge and covenant not to sue Camp Good Days and Special Times and its officers, directors, servants, agents and employees from all liability, costs, expenses and claims, demands, actions and causes of action whatsoever arising, that may be sustained by me, or to any property belonging to me, whether caused by negligence of CampGoodDays orotherwise.

I am fully aware of the risks and hazards, known and possibly unknown to me, associated with being on the Premises and participating in the Camp. I hereby elect to voluntarily enter upon the Premises and participate in the Camp and assume full responsibility for any risks of loss, property damage, or personal injury, that may be sustained by me, or any loss or damage to property owned by me, as a result of my being a participant in the Camp, whether caused by negligence of Camp Good Days or otherwise.

_____ _____

Parent/Guardian Signature Date

IV. PHOTO/ AUDIO-VISUAL/ MEDIA RELEASE:

I hereby grant permission to participate in any audio-visual event (including photos and videos for future Camp use) that may take place in regard to this program and release Camp Good Days and Special Times, Inc., and everyone involved of any liability or claims in association with the media coverage if such takes place.

PLEASE CHECK ONE: YES ☐ or NO ☐ (If No, please be aware of this responsibility)

_____ _____

Parent/Guardian Signature Date