

Town of Ticonderoga

Summer Program 2018

The program will run from Monday, July 9 through Friday, August 10, from 7:30 AM – 2:30 PM at the Ticonderoga Elementary/Middle School (towards back of building - the cafeteria side entrance)

The cost is \$10.00 per day.

The registration, medical and health record forms, and payment can be given to the town clerk at any time. You can obtain them at the Town Clerk's Office or off the Town's Website - townofticonderoga.org - Youth Department

Pre-Registration and payment is required.

You can choose to send your child to the program every day or you can choose what days your child will attend.

If you should have any questions please contact the Town Clerks Office at (518)-585-6677.

Town of Ticonderoga

Summer Program 2018

Kindergarten to age 13

Registration fee \$10.00 per day

Name:

Address

City _____ State _____

Zip _____

Phone _____

or _____

Name of the child(ren) along with the age of the child(ren) that you are registering for the Summer Program and dates of attendance:

| Name | Age | Dates Attending |
|------|-----|-----------------|
|------|-----|-----------------|

Signature _____

____ Date _____

Ticonderoga Summer Youth Program

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health & Association of Camp Nurses

Mail this form to:

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last
 Male Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

Camper Name _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.
- 2) Send the original, signed FORM 1 to camp by the requested date.
- 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
- 4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____)

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet.
 This camper has special food needs. *(Please describe below.)*

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____
Subscriber _____ Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name:

First

Middle

Last

Birth Date:

Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

| Immunization | Dose 1 Month/Year | Dose 2 Month/Year | Dose 3 Month/Year | Dose 4 Month/Year | Dose 5 Month/Year | Most Recent Dose Month/Year |
|--|---|----------------------|----------------------|----------------------|----------------------|--------------------------------|
| Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP) | | | | | | |
| Tetanus booster ★ (dT) or (TdaP) | | | | | | |
| Mumps, measles, rubella ★ (MMR) | | | | | | |
| Polio ★ (IPV) | | | | | | |
| Haemophilus influenzae type B (HIB) | | | | | | |
| Pneumococcal (PCV) | | | | | | |
| Hepatitis B | | | | | | |
| Hepatitis A | | | | | | |
| Varicella (chicken pox) | <input type="checkbox"/> Had chicken pox Date: | | | | | |
| Meningococcal meningitis (MCV4) | | | | | | |

Tuberculosis (TB) test Date: Negative Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial
Parent/Guardian: _____

Date: _____

Relationship
to Camper: _____

Medication: This camper will not take any daily medications while attending camp. (must include medication orders)
 This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

| Name of medication | Date started | Reason for taking it | When it is given | Amount or dose given | How it is given |
|--------------------|--------------|----------------------|---|----------------------|-----------------|
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: | | |
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: | | |
| | | | <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: | | |

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those the camper should not be given.**

Acetaminophen (Tylenol)
 Phenylephrine decongestant (Sudafed PE)
 Antihistamine/allergy medicine
 Diphenhydramine antihistamine/allergy medicine (Benadryl)
 Sore throat spray
 Lice shampoo or cream (Nix or Elimite)
 Calamine lotion
 Laxatives for constipation (Ex-Lax)

NIA

Ibuprofen (Advil, Motrin)
 Pseudoephedrine decongestant (Sudafed)
 Guaifenesin cough syrup (Robitussin)
 Dextromethorphan cough syrup (Robitussin DM)
 Generic cough drops
 Antibiotic cream
 Aloe
 Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Imodium
 Tums
 Maalox

CAMPER HEALTH HISTORY FORM 1

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Camper Name: _____

First

Middle

Last

Birth Date: _____

Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- | | |
|---|---|
| 1. Ever been hospitalized? . <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? . <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?. .. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

- | |
|---|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?..... <input type="checkbox"/> Yes <input type="checkbox"/> No (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) |

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

Ticonderoga Summer Youth Program

Prescription Medications

Individualized Orders for: Camper's Name: _____

Birth Date: _____ Weight: _____

| Drug Name | Route | Dosage | Indication | Comments |
|-----------|-------|--------|------------|----------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Camper's Health Care Provider Name: _____

Address: _____

License#: _____ Phone #: _____

Dr. Signature: _____ Date: / /

Parent Signature _____

Date / /

CAMPER HEALTH HISTORY FORM 1

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Individual Health Record (For Camp Use Only)

Initial Screening

Date/Time: _____

Initials: _____

- Screening has been conducted according to camp protocol and significant findings noted as follows:
- A. Any signs/symptoms of illness or injury upon arrival?..... No Yes as noted below
 - B. History of exposure to communicable disease?..... No Yes as noted below
 - C. Additions or corrections to information on this health history?..... No Yes as noted below
 - D. Medication given to health-care staff?..... No Yes as noted below
 - E. Any signs/symptoms of head lice?..... No Yes as noted below

Provider notes: (date/time/initial all entries) _____

Exit Note: Check one of the following:

- Left camp this day with no reported illness or injury symptoms.
- Left camp this day with the following problem/concern:

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____