



# HEALTH FORMS – PHYSICIAN

Form must be completed AND signed by a licensed health-care provider.

Please review the HEALTH FORMS and complete all sections of this form. Fax this form, by June 1<sup>st</sup>, to (607) 865-6532.

CAMPER NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

IMMUNIZATION HISTORY: Please provide a current vaccination record which includes name of vaccines and dates administered.

PHYSICAL EXAM: Done Today?  YES  NO If NO, date of last physical: MM/DD/YEAR \_\_\_\_\_

Has this camper been diagnosed with a developmental disability?  YES  NO If yes, please explain: \_\_\_\_\_

Camper is undergoing treatment at this time for the following condition(s): \_\_\_\_\_

MEDICATION AUTHORIZATION: If a licensed healthcare provider does not sign this form, the camper will NOT be given any prescription or over-the-counter medication while at camp. This includes for scrapes, bee stings, bug bites, etc.

### Over the Counter (OTC) Medications kept on hand in our infirmary.

| DRUG NAME                      | CIRCLE ROUTE                     | DOSAGE                               | SCHEDULE & INDICATIONS                                   | PERMISSION TO ADMINISTER | PROVIDER INITIALS REQUIRED |
|--------------------------------|----------------------------------|--------------------------------------|--|--------------------------|----------------------------|
| Ibuprofen (Advil/Motrin)       | Elixir, tabs, or Chewable        | Per Label Instructions by age/weight | Q 4hr for pain or fever> _____ <sup>oF</sup>             | YES or NO                |                            |
| Acetaminophen (Tylenol)        | Elixir, tabs, or Chewable        | Per Label Instructions by age/weight | Q 4hr for pain or fever> _____ <sup>oF</sup>             | YES or NO                |                            |
| Antacids (Tums)                | Pills or liquid                  | Per Label Instructions by age/weight | Q 2-4 hrs PRN gas, heartburn, indigestion, upset stomach | YES or NO                |                            |
| Diphenhydramine (Benadryl)     | Elixir, tabs, pills, or Chewable | Per Label Instructions by age/weight | Q 6 hr PRN for allergic reaction, (hives, insect bite)   | YES or NO                |                            |
| Loratadine (Claritin)          | Elixir, tabs, pills, or Chewable | Per Label Instructions by age/weight | Q 6 hr PRN for allergic reaction, (hives, insect bite)   | YES or NO                |                            |
| Cough Drops                    |                                  | Per Label Instructions by age/weight | PRN for cough or sore throat                             | YES or NO                |                            |
| Dextromethorphan (Cough Syrup) | Liquid                           | Per Label Instructions by age/weight | Q 4hrs PRN for cough                                     | YES or NO                |                            |
| Hydrocortisone                 | Topical Cream                    | Per Label Instructions               | Q 6 -8 hrs PRN rash, skin irritation, insect bites       | YES or NO                |                            |
| Antiseptics / Antibiotic       | Topical Cream                    | Per Label Instructions               | PRN stings/bites, cuts, scrapes, splinters, blisters     | YES or NO                |                            |
| Antifungal                     | cream, spray, or powder          | Per Label Instructions               | PRN Athletes foot, jock itch                             | YES or NO                |                            |

### Other Medications to be brought to camp with the camper (Prescription or PRN – Including Inhalers).

| DRUG NAME | ROUTE | DOSAGE | SCHEDULE & INDICATIONS | PROVIDER INITIALS REQUIRED |
|-----------|-------|--------|------------------------|----------------------------|
|           |       |        |                        |                            |
|           |       |        |                        |                            |
|           |       |        |                        |                            |

ALL medications MUST be in their ORIGINAL CONTAINERS and surrendered to the Camp Nurse at registration!

Please consider sending only what your child needs for their stay at Camp. This prevents problems if meds are forgotten at pick up.

Do you feel this camper will require limitations or restrictions while at camp:  YES  NO If yes, please explain:

I have reviewed the HEALTH FORMS, and have discussed the camp program with the camper’s parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of Licensed Physician/Provider (PRINT): \_\_\_\_\_  
Signature of Licensed Physician/Provider: \_\_\_\_\_ License # \_\_\_\_\_  
Office Address: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: (        ) \_\_\_\_\_ Date: \_\_\_\_\_



# HEALTH FORMS – PARENT/GUARDIAN 1

**DUE JUNE 1ST** ~ PLEASE DON'T WAIT TO CONTACT YOUR PHYSICIAN.

**CAMPERS NAME:** \_\_\_\_\_

**WEEK(S) ATTENDING CAMP:**

LAST, FIRST MIDDLE

WEEK 1

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

WEEK 2

WEEK 3

**EMERGENCY CONTACT: PARENT / GUARDIAN**

WEEK 4

WEEK 5

Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Home Address: \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

**IN THE EVENT I CANNOT BE REACHED, please contact:** (Must be over 18 years of age)

1) Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Home Address: \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

2) Name: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Home Address: \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

**FAMILY PHYSICIAN:** Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Office Address: \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**MEDICAL INSURANCE:** Fill out completely OR attach a copy of your insurance card. Both sides must be readable.

This camper is covered by family medical/health insurance: \_\_\_\_\_ YES \_\_\_\_\_ NO

| Policy Holder's Name:   | Name of Insurance carrier and type of coverage | Policy Number | Group Number |
|---|--|---------------|--------------|
| Authorization for release of information      Signature _____      Date _____<br>Address of Insurance Company _____ |  |               |              |

**PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:**

I certify that the information given in these health forms is current, correct, and accurately reflects the health status of the camper to whom it pertains. I hereby give permission to the medical personnel selected by the Camp Administrator to order x-rays, routine tests, treatment, release any records necessary for insurance purposes, and to provide or arrange for necessary transportation of my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Administrator to secure and administer treatment, including hospitalization, for the person named above. 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. Those providers may talk with camp staff about my child's health status.

Signature of Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



# HEALTH FORMS – PARENT/GUARDIAN 2

GENERAL HEALTH HISTORY – PLEASE FILL IN ALL INFORMATION. WRITE N/A IF APPROPRIATE.

CAMPER NAME: \_\_\_\_\_

First Time Overnight?  YES  NO

Does camper have a history of . . .

- YES  NO Asthma / Wheezing / Short of Breath
- YES  NO Bedwetting
- YES  NO Bleeding / Clotting Disorders
- YES  NO Concussion / Head Injury
- YES  NO Diabetes
- YES  NO Diarrhea or Constipation
- YES  NO Ear Infections
- YES  NO Eating Disorder
- YES  NO Fainting / Dizziness
- YES  NO Headaches
- YES  NO Heart Defect / Disease
- YES  NO Hypertension
- YES  NO Mononucleosis
- YES  NO Psychiatric Treatment
- YES  NO Seizures / Convulsions
- YES  NO Skin Irritation / Condition
- YES  NO Sleepwalking

Developmental Disability: \_\_\_\_\_

Other Disability or Chronic Condition(s): \_\_\_\_\_

Operations/Serious Injuries (dates): \_\_\_\_\_

Traveled outside the country in the past 9 months? (When/Where) \_\_\_\_\_

**DIET:** This camper eats a . . . (Please check one).

- Regular diet
- Vegetarian diet
- Dietary Restrictions – Please explain: \_\_\_\_\_

*What have we forgotten to ask about? Please explain any other concerns:* \_\_\_\_\_

**FOR GIRLS:**

- YES  NO Has this camper menstruated?
- YES  NO If not, has she been told about menstruation?
- YES  NO If so, is her menstrual cycle normal?

**MENTAL / EMOTIONAL / SOCIAL HEALTH:** Has the camper:

- YES  NO Ever been treated for attention deficit disorder (ADD) OR attention deficit hyperactivity disorder (ADHD)?
- YES  NO Ever been treated for emotional or behavioral difficulties or an eating disorder?
- YES  NO During the last 12 months, seen a professional to address mental/emotional health concerns?
- YES  NO Had a significant life event that continues to affect the camper’s life? (death of a loved one, family change, etc.)

If yes, please explain (separate sheet may be used if necessary): \_\_\_\_\_

**ALLERGIES:** Please specify allergy and typical reaction.

| Environmental Allergies | Food Allergies | Drug Allergies | Insect Stings / Other Allergies |
|-------------------------|----------------|----------------|---------------------------------|
| _____                   | _____          | _____          | _____                           |
| _____                   | _____          | _____          | _____                           |

**Inhalers & Epi-Pens:** The Camp Health Director / Nurse must keep the primary. If you would like your camper to carry, you must provide a second inhaler or epi-pen. Please note that Camp is NOT responsible for lost items, including inhalers or epi-pens.

- YES  NO Has your camper been trained in the proper use of their inhaler or epi-pen?
- YES  NO Does your camper have parental consent to carry their (second) inhaler or epi-pen?

**MENINGOCOCCAL MENINGITIS VACCINATION:** NYS Public Health Law requires a completed response on all campers.

- 1)  My child has received meningococcal immunization (Menactra or Menveo) within the last 10 years.  
\_\_\_\_\_ **Date received (REQUIRED)**
- 2)  I have read the information available to me 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.
- 3)  My child is not old enough to receive the meningococcal meningitis vaccine. *Note: The first dose is usually given at age 11.*

**SIGNATURE OF PARENT / GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

## ASSUMPTION OF RISK FORM

(Form must be completed prior to participation)

I hereby apply for my child to participate in the summer residence camp program indicated below to be conducted by the designated Cornell Cooperative Extension Association and acknowledge as follows:

I fully understand and acknowledge that there are inherent risks and dangers in my child's participation in the camp and its programs and activities and that my child's use of any equipment related to such activities and programs may result in injury, disability, illness or death and damage to personal property. I understand other participants, accidents, forces of nature or other causes may also cause these risks and dangers. I hereby fully accept and agree to such risks and dangers, both known and unknown.

My child is in good health and is at or above the minimum age of six (6) required to participate in Camp and all activities including those listed below and he/she is able to participate in any strenuous physical activity associated therewith. I affirm that I have read all camp materials describing the various activities and programs conducted by the Camp.

**Name of camp:** 4-H CAMP SHANKITUNK  
**Location:** 2420 ARBOR HILL ROAD, DELHI, NY 13753

**Camp activities:** All camp activities, including but not limited to, swimming, hiking, fishing, basketball, volleyball, soccer, baseball, archery, ropes course/team challenge, rocketry, woodworking, arts and crafts, and cooking.

**Dates:** JULY 1, 2018 - AUGUST 3, 2018

**Note:** Activities listed above may involve competition between both boys and girls or coed teams.

**Swimming:** Does your child have permission to swim?  
(Required for children with a developmental disability)  
 YES  NO

I have read the above and by signing it I agree it is my intention to have my child participate in the Camp and all activities and programs of the Camp. and I understand and fully accept the risks involved. This shall be binding on my heirs, successors, assigns, administrators and executors. Any claims or disputes arising out of my child's participation in 4-H Camp Shankitunk activities shall be venued in the Supreme Court of the State of New York, Delaware County.

**I am at least twenty-one (21) years of age and I am the legal parent/guardian authorized to sign on the behalf of any other parent/guardian of the child named herein.**

Participant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## CODE OF CONDUCT

(Form must be completed prior to participation)

The following ground rules are designed to make the experience at 4-H Camp Shankitunk safe and satisfying for everyone attending camp this summer.

- 1. Participate** - Everyone is expected to participate in all activities. No camper may leave the grounds unless permission is secured from the Camp Director or administrator.
- 2. Create a Welcoming Environment for All** - Recognize that everyone has skills and talents to contribute. Though we may not always agree, we must disagree respectfully.
- 3. Bring Your Best Self** - Respect and follow the rules. Conduct yourself in a manner that reflects honesty, integrity, and self-control. Fighting, obscene or discriminatory language; and insubordination are never acceptable.
- 4. Obey the Law** - Commit no illegal acts. Do not possess or use illegal drugs, tobacco products, firearms, weapons, or any harmful object with the intent to hurt others at any time.
- 5. Honor Diversity - Yours and Others.** Respect the rights and dignity of everyone. Cornell Cooperative Extension is an equal opportunity, affirmative action educator and employer.
- 6. Create a Safe Environment.** Do not carelessly/intentionally harm other youth or adults in any way (verbally, mentally, physically, or emotionally). Refrain from romantic displays and sexual activities. Be kind and compassionate. Harassment, bullying, and other exclusionary behavior are not acceptable.
- 7. Watch What You Wear** - Use your best judgment. Wear clothing suited for the activity you will participate in. Don't wear clothing that reveals underwear, midriff, buttocks, or cleavage, etc. Clothing promoting intoxicants or displaying inappropriate/discriminatory messages are never acceptable.
- 8. Recognize off-limit areas** - These are places where the campers are not allowed to go unless an adult is accompanying them. In addition, everyone must keep to their designated lodging areas: boys may not be in girls' units/tents/bathrooms and girls may not be in boys' units/tents/bathrooms.
- 9. Respect Rest Times** - All participants are to be in their assigned area at curfew and to comply with the quiet hours, lights out, and other rules of the camp, including rest time after lunch.
- 10. Say Something** - Help others by promptly reporting any violations or infractions of these rules to the Camp Director.

We have a three strike discipline policy. *The Camp Director, in his/her sole discretion, may waive the three strike policy and send a camper home depending upon the level of camper misconduct.* Campers violating camp rules, policy, or code of conduct will be dealt with as follows:

- First Offense:** Counselor or other official will provide a verbal warning.  
**Second Offense:** Director or designee will meet with camper and call home.  
**Third Offense:** The camper will be sent home.

**I have read the Code of Conduct with my camper and he/she agrees to abide by the rules outlined above.**

Participant's Name: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please Complete and Return to 4-H Camp Shankitunk by June 1<sup>st</sup>.

## PHOTO/VIDEO RELEASE FORM

Cornell Cooperative Extension (CCE) and Cornell University are granted permission to use and/or publish my or my child's photograph or image (including audio, film, digital image or any other media) for educational purposes, on their respective websites or for promotion of their respective programs.

I understand that I/my child/ward are not being compensated in any way for the use of our images and that I/we do not have approval over the final product in which it appears. I hereby release Cornell Cooperative Extension and Cornell University and all persons acting under their permission or authority from any and all claims or liability arising out of use of our images. This release shall bind our heirs, guardians, assigns, and legal representatives.

YES

NO

**I am at least at least twenty-one (21) years of age and I am the legal parent/guardian authorized to sign on the behalf of any other parent/guardian of the child named herein.**

Participant's Name: \_\_\_\_\_

Name of Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## EMERGENCY TRANSPORTATION RELEASE

I, the undersigned parent/guardian of:

Participant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**DO** hereby give permission to authorized, licensed representatives of 4-H Camp Shankitunk to provide transportation in an authorized vehicle for my child in the event of a weather or medical emergency.

Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## DEMOGRAPHIC REPORTING

*(Please assist us in achieving our goal of inclusiveness)*

Cornell Cooperative Extension provides equal program and employment opportunities. In an effort to assist us in achieving our goal of inclusiveness, please take a moment to provide the following information about your camper. *This information will ONLY be used for federal reporting purposes.*

**ETHNICITY** *(Check One)*

Hispanic  Non-Hispanic

**RACE** *(Check One)*

Caucasian  African American

Asian  Native American

Pacific Islander/  
Native Hawaiian  Other:

## REFUND/CANCELLATION POLICY

**All refund requests must be made in writing. There will be a processing fee of \$75.00 per session applied to all refunds.**

Upon arrival, if it is determined that a camper is too ill to attend, the camper will be sent home immediately. No refund issued. In the event a camper becomes ill while at camp and is sent home at the discretion of the Camp Nurse, no refund will be issued.

In the interest of the health and wellness of all campers, those campers who cannot adjust to camp (e.g. severe homesickness, bed wetting, disruptive or dangerous behavior, non-compliance, etc.) may be sent home at the discretion of the Camp Director. No refund will be issued.

Full refunds minus the applicable processing fees will only be considered for emergency situations. An emergency situation is defined as a specific medical condition (e.g. injury, illness or hospitalization) or a certain family situation (e.g. death in family).

**Please note that requests for refunds will be subject to review and may take time to process.**

Camper's Name: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_