CAMP OLMSTED 2012

Dear Parent/Guardian:

Enclosed are registration forms for you to complete for your child's camp registration.

- ❒ Space Reservation Form (**Along with $25 registration fee**);
- ❒ Registration Form;
- ❒ Health Form;
- ❒ Medication Form;
- ❒ Emergency Treatment Consent Form;
- ❒ USDA Eligibility Form;
- ❒ Meningococcal Meningitis Vaccination Form; and
- ❒ Scholarship Form (Only if you are requesting a scholarship)

You will also need to include copies of the following:

- ❒ Birth Certificates of all children registered for camp;
- ❒ Health insurance/Medicaid card;
- ❒ Immunization Record; and
- ❒ Social Security card

Please mail completed forms and **MONEY ORDERS** to:

Five Points Mission
475 Riverside Drive, Suite 1922
New York, NY 10115
ATTN: Camp Registration

Registration begins January 30th at 475 Riverside Drive (Between 119th &120th street and Claremont Ave). To make an appointment call 212-870-3084 ext. 6. In addition we will be available to assist you on the following evenings and weekends.

- Registration Dates -

| **Early Bird Registration** | | |
|---|---|---|
| Wednesday | February 23rd | 10am – 3pm |
| **Evening Registration** | | |
| Tuesday | May 1st | 3pm – 7pm |
| *Thursday | May 17th | 3pm – 7pm |
| (Special Parent Orientation @ 6pm) | | |
| Wednesday | June 6th | 3pm – 7pm |
| **Weekend Registration** | | |
| Saturday | June 23rd | 10am – 2pm |
| Saturday | July 7th | 10am – 2pm |
| Saturday | July 28th | 10am – 2pm |

We thank you for your continued interest in Camp Olmsted, and look forward to serving you and your family this summer.

You can also visit our website at:

www.campolmsted.org

# CAMP OLMSTED INFORMATION

## 2012

**PLEASE NOTE OUR REVISED SCHEDULE**
**FOR SUMMER 2012, THE SESSIONS ARE AS FOLLOWS:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **SESSION 1** | **(Monday)** | **June 25th** | **-** | **(Friday)** | **July 6th** | **$370** | |
| **SESSION 2** | **(Monday)** | **July 9th** | **-** | **(Friday)** | **July 20th** | **$370** | |
| | **(Friday)** | **July 20th** | **-** | **(Friday)** | **July 27th** | **$200** | **(Extended Session)** |
| **SESSION 3** | **(Monday)** | **July 30th** | **-** | **(Friday)** | **August 10th** | **$370** | |

***Our camping fee is per child/per session and includes lodging, meals and all activities. Transportation to our facilities will be available for students from upper Manhattan.***

**THERE IS A $25.00 NONREFUNDABLE REGISTRATION FEE PER CHILD**

**THE PROGRAM FEE PER SESSION IS $370.00 PER CHILD (*for the first child*)**

**($350.00 PER ADDITIONAL CHILD OR SESSION)**

*The Extended Session is available for the discounted rate of $175 for those attending session 2 from July 9th – July 20th

**THE OLMSTED CAMP PROGRAM SERVES**
Boys & Girls: Ages 6 - 13 Years

**PLEASE MAKE MONEY ORDER PAYABLE TO FIVE POINTS MISSION AND MAIL TO:**
**Five Points Mission,**
**475 Riverside Drive, Room 1922**
**New York, NY 10115**
**Attention: Camp Registration**

- ✓ **Payment plans and limited full & partial scholarships are available for families who qualify.**
- ✓ **Families on public assistance may be eligible for government reimbursements.**
- ✓ **Full refunds of camp fees (not including $25 registration fee) are available for cancellations made a minimum of 14 days in advance.**
- ✓ **Space reservations are not guaranteed until full payment has been received.**

www.campolmsted.org

# SPACE RESERVATION FORM 2012

# *CAMP OLMSTED*

**PLEASE COMPLETE ONE FORM FOR EACH CHILD.**
***REMEMBER TO INCLUDE A REGISTRATION FEE OF $25.00 FOR EACH CHILD.***
**MONEY ORDERS ONLY**

Parent Name: ______________________________________________
(Please Print Clearly)

Address: ______________________________________________

______________________________________________

Home Phone: ______________________ Work Phone: __________________ Ext: ________

Other Phone: ______________________ E-mail Address: __________________________

Child's Name: ________________________________ Date of Birth: __________________

Sex: Male ❑ Female ❑ T-Shirt Size: __________________

Check the approximate box below to indicate the session you would like your child to attend:

❑ Session I June 25th - July 6th
❑ Session II July 9th - July 20th
❑ Extended Week July 20th - July 27th
❑ Session III July 30th - Aug 10th

Has your child attended camp before? __________ If yes, which camp? __________________

Is your child on medication? _________ If yes, what type of medication? ________________

Does your child have any special needs? ______________________________________

Other information we should have about this child ________________________________

How did you learn about Camp Olmsted? ______________________________________

Does your child qualify for public assistance? ❑ Yes ❑ No

Will you be applying for a camp scholarship? ❑ Yes ❑ No

Would you be interested in attending a Parent Orientation Session? ❑ Yes ❑ No

I certify that the information on this form is accurate.

Parent's Signature: ________________________________ Date: ____________

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Revised: 2006-2012

# REGISTRATION FORM 2012

Child's Last Name ______________________ First ____________________ MALE ☐ FEMALE ☐

C/O Last Name ________________________ First _____________ Child's Date of Birth ____________

Address ______________________________ City, State ____________________ Zip ____________

Home Phone __________________________________ Primary Language Spoken: ________________

School ___________________________ Current Grade ____ Education: ☐ Regular ☐ Special (type) ___

**2012 Season:**

❒ Session 1: June 25 – July 6

❒ *Session 2: July 20 – July 27 (Extended Session)

❒ Session 2: July 9 – July 20

❒ Session 3: July 30 – August 10

Referring Church/Agency: (if applicable) ____________________________________

| FAMILY DATA | Check if child lives with this person | Home Telephone Number(s) | Work/Cellular Telephone Number(s) |
|---|---|---|---|
| Mother's Name | | ( ) | ( ) |
| Father's Name | | ( ) | ( ) |
| Foster Parent's Name | | ( ) | ( ) |
| Guardian's Name | | ( ) | ( ) |

# of Brothers _____ Ages ________ # of Sisters ____ Ages ______ # of people living in the home _____

Is child currently in foster care? ☐ Yes ☐ No If yes, agency name ______________________

Case Worker's Name ______________________ Case Worker's Phone # ______________________

**EMERGENCY CONTACTS** **Two people who will be responsible for the child if the parent or guardian is not available.**

#1 Name __________________________ Relationship ____________ Phone (____) ______________

#2 Name __________________________ Relationship ____________ Phone (____ ) ______________

**PUBLIC ASSISTANCE INFORMATION**

AFDC # ______________________________________ IM CENTER ______________________

**HEALTH INSURANCE DATA**

Medicaid Number _________________________

Medical Plan/Insurance ______________________ ID or Policy Number ______________________

***❋PLEASE ATTACH A COPY OF CHILD'S MEDICAID CARD OR MEDICAL INSURANCE CARD TO REGISTRATION FORM.❋***

# REGISTRATION FORM 2012

## Parent Comments

Is your child most comfortable speaking a language other than English? ☐ No ☐ Yes If yes, please specify: ______

Is your child's appetite: ☐ light ☐ average ☐ hearty Any **food allergies**? ______________________

Is your child a vegetarian? ☐ No ☐ Yes

Any other allergies? ______________________

What are your child's favorite foods? ______________________

Can your child swim? ☐ No ☐ Yes If yes, where did he or she learn? ______________________

Does your child like: ☐ Art ☐ Swimming ☐ Reading ☐ Hiking ☐ Singing ☐ Dancing ☐ Nature Studies
☐ Cooking ☐ Drama ☐ Other: ______________________

Does your child: ☐ Have Nightmares ☐ Sleepwalk ☐ Wet the bed

Does your child fear: ☐ The Dark ☐ Heights ☐Water ☐ Other ______________________

Has your child been away from home before? ☐ No ☐ Yes If yes, where? ______________________

What words would you use to describe your child? ______________________

______________________

Do you have any special recommendations for the care of your child? ______________________

______________________

How does your child handle conflicts with adults? ______________________

How does your child handle conflicts with other children? ______________________

Is there anything else you would like to tell us about your child? ______________________

______________________

Are you a member of a Methodist Church? (Optional) ☐ No ☐Yes If yes, which one? ______________________

### For the Parent

1. I have read and understand Camp Olmsted's goals, activity list and fact sheet. I give my child permission to participate in these activities.
2. I understand that in order to remain at camp, my child must cooperate with the camp policies and activities.
3. I give consent for medical, surgical or dental treatment including hospitalization for my child, if necessary, while he or she is away.
4. I permit, Five Points Mission, in case of illness or accident, to use the proceeds of whatever hospitalization or medical coverage my child may have.
5. I give consent for medical personnel treating my child to release any medical records to Five Points Mission.
6. I give permission for my child to be transported in privately owned vehicles for out-of-camp activities in case of emergency.
7. I give permission for Five Points Mission to use pictures in which my child might appear to help publicize Camp Olmsted.

Signature of Parent/Legal Guardian: ______________________

Print Name: ______________________

Relationship to Child: ______________________ Date: ____________

# 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 the address below by _______ (date)***

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

***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 Name ______________ First ______________ Middle ______________ Last ______________ (For Camp Use) Cabin or Group______________ (For Camp Use) Session Code(s): ______________

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.***

# 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 |
|---|---|---|---|---|---|---|
| Diptheria, 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) ☐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.
☐ 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 |
|---|---|---|---|---|---|
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____________ | | |
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____________ | | |
| | | | ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐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)

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)

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# 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

**<u>General Health History</u>: *Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

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

**<u>Mental, Emotional, and Social Health</u>: *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)? …………………………....... ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?……............................................................................ ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?……..…………………………………… ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life?...................................................................................................... ☐ Yes ☐ 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.

**<u>Health-Care Providers</u>:**

Name of camper's primary doctor(s): ______________________________ Phone: (________) ________________________

Name of dentist(s):______________________________________ Phone: (________) ________________________

Name of orthodontist(s):__________________________________ Phone: (________) ________________________

**<u>What Have We Forgotten to Ask?</u>** ***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.***

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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

## 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: __________

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CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL FORM 2

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

***Mail this form to the address below by _______ (date)***

***To Parent(s)/Guardian(s): Complete this section** and give **this form (FORM 2)** and **a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1)** to your child's health-care provider for review.*

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 home address: ____________________________________________

____________________________________________
City State Zip Code

Custodial parent(s)/guardian(s) phone: (_______)______________ (_______)____________

***Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.***

Camper Name ______________ First ______________ Middle ______________ Last ______ (For Camp Use) Cabin or Group______________ (For Camp Use) Session Code(s): ______________

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

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

***Medical Personnel:* Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.**

**Physical exam done today:** ☐ Yes ☐ No (**If "No," date of last physical**: ___________)
Month/Day/Year

**ACA accreditation standards specify physical exam within last 12 months.**

Weight: _______ lbs Height: _____ft_____in Blood Pressure_______/_______

**Allergies:** ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

***Describe previous reactions:***

**Diet, Nutrition:** ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions: ***(describe below)***

**The camper is undergoing treatment at this time for the following conditions:** ***(describe below)*** ☐ None.

**Medication:** ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

**Other treatments/therapies to be continued at camp:** ***(describe below)*** ☐ None needed.

**Do you feel that the camper will require limitations or restrictions to activity while at camp?** ☐ No ☐ Yes

***If you answered "Yes"*** to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

**"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), 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 provider (please print): ___________________________Signature: __________________________Title: _________

Office Address____________________________________________________
Street City State Zip Code

Telephone: (________)____________________ Date:______________________

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# MEDICATION FORM 2012

# CAMP OLMSTED

**This form must be signed and stamped by the health care provider if your child IS taking prescription or over the counter medication.**

**If the child is NOT taking medication only the parent signature is required.**

Camper Name: ____________________________________________ DOB ___/___/_____

Parent/Guardian Name: _____________________________________ Session: __________

**Prescription or "over-the-counter" medication should be in its original container and placed in a zip-lock bag for transportation to the camp with a note authorizing the nurse to dispense medication. All medication will be distributed by the camp nurse at the prescribed times. All medication should have the child's name on it.**

**No over-the-counter medications can be dispensed without completion of this form.**

**Prescription Medications**

*Must complete with camper's current regimen for both scheduled and PRN medications* (use 2nd page if needed)

| DRUG NAME | ROUTE | DOSAGE | SCHEDULE & INDICATIONS | COMMENTS |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Health Care Provider (MD, NP, PA)**

Name ________________________________________ Phone ______________________________

Address ______________________________________ License # ____________________________

Signature _____________________________________ Date _____/_____/________

**Standard Over the Counter Medications provided at Camp Olmsted include:**

*Please indicate if your child CAN NOT receive any of the following.*

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)

❒ DO NOT give my child Acetaminophen (Tylenol)
❒ DO NOT give my child Ibuprofen (Advil, Motrin)
❒ DO NOT give my child Phenylephrine (Sudafed PE)
❒ DO NOT give my child Pseudoephedrine (Sudafed)

- Over -

# MEDICATION FORM 2012

- Chlorpheneramine Maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic Cough Drops
- Chloraseptic (Sore throat spray)
- Lice Shampoo/scabies cream (Nix or Elimite)
- Calamine Lotion
- Bismuth Subsalicylate (Pepto-Bismol)
- Laxative for constipation
- Hydrocortisone 1% cream
- Topical Antibiotic Cream
- Aloe

❒ DO NOT give my child Chlorpheneramine Maleate
❒ DO NOT give my child Guaifenesin
❒ DO NOT give my child Dextromethorphan
❒ DO NOT give my child Diphenhydramine (Benadryl)
❒ DO NOT give my child Generic Cough Drops
❒ DO NOT give my child Chloraseptic (Sore throat spray)
❒ DO NOT give my child Lice Shampoo or scabies cream (Nix or Elimite)
❒ DO NOT give my child Calamine Lotion
❒ DO NOT give my child Bismuth Subsalicylate (Pepto-Bismol)
❒ DO NOT give my child Laxative for constipation
❒ DO NOT give my child Hydrocortisone 1% cream
❒ DO NOT give my child Topical Antibiotic Cream
❒ DO NOT give my child Aloe

**For more information on these medications please consult your child's health care provider.**

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## Standard over the Counter Medications

*Any over the counter medications the student plans to bring to camp must be added to this list.*

| DRUG NAME | ROUTE [PLEASE CIRCLE PREFERRED FORMULATION(S)] | DOSAGE | SCHEDULE & INDICATIONS | CAMPER HEALTHCARE PROVIDER ORDER | COMMENTS |
|---|---|---|---|---|---|
| | | | | ❒ Y ❒ N | |
| | | | | ❒ Y ❒ N | |
| | | | | ❒ Y ❒ N | |
| | | | | ❒ Y ❒ N | |
| | | | | ❒ Y ❒ N | |

______________________________ Parent/Guardian's Signature

____/____/______ Date

For Office Use Only:

Prescribed Medication: ______________________________ Time: ______________

Refrigerate: Yes ❒ No ❒

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# EMERGENCY CONSENT FORM 2012

**CAMP OLMSTED**
**475 RIVERSIDE DRIVE – ROOM 1922**
**NEW YORK, NY 10115**

**APPOINTMENT OF LEGAL REPRESENTATIVE TO AUTHORIZE TREATMENT OF MINOR**

**I am the parent or legal guardian of the following minor child (under 18):**

**Child's Legal Name:** ______________________________ ______________________________
(LAST NAME) (FIRST, MIDDLE NAME)

**Date of Birth:** ___________________ **Date of Last Tetanus Shot or D.P.T.:** _________________

**Known Allergy of Specific Medical Condition:** ____________________________________________

______________________________________________________________________________

**Child's Pediatrician:** ________________________________**Phone Number:** (___) _______________

**Mother:** _____________________ **Business Phone:** (___) _________ **Home Phone:** (___) __________

**Father:** _____________________ **Business Phone:** (___) _________ **Home Phone:** (___) _________

**I hereby appoint:** Carla Maisonet (845) 534-7900 Olmsted Center Director
(845) 534-7900 Camp Olmsted Director

**Who are of lawful age, as my legal representatives for the purpose of authorizing and consenting to emergency medical care and treatment only, for the child listed above, should such care be required and I am unavailable to give such consent.**

**I understand and agree that I am responsible for the charges incurred for authorized care rendered for the above named minor.**

**This authorization will expire on the child's 18th birthday, and may be revoked in writing at any time. I understand that I may change my legal representatives at any time.**

______________________________________________________________________
(PRINT NAME OF PARENT OR GUARDIAN)

______________________________________________________________________
(SIGNATURE OF PARENT OR GUARDIAN)

______________________________________________________________________
(MAILING ADDRESS)

_______________________________________
(TODAY'S DATE)

WWW.CAMPOLMSTED.ORG

Five Points Mission
Camp Olmsted
475 Riverside Drive, Room 1922
New York, NY 10115
Telephone: (212) 870-3084

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003.

Camp Olmsted is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent or guardian; AND
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 13 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States – type A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among teens and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at www.miningitisvaccine.com.

I encourage you to carefully review the enclosed materials. Please complete the Meningococcal Vaccination Response Form and return it to Camp Olmsted Staff.

To learn more about meningitis and the vaccine, consult your child's physician. You can also find information about the disease at the New York State Department of Health website: www.health.state.ny.us, and www.cdc.gov/ncidod/dbmd/diseaseinfo.

Sincerely,

Camp Olmsted Staff

**What is Meningococcal Disease?**

Meningococcal Disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord) caused by the meningococcus germ.

**Who gets Meningococcal Disease?**

Anyone can get Meningococcal Disease, but it is more common in infants and children. For some adolescents, such as first year college students living in dormitories, there is an increased risk of Meningococcal Disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease. Other persons at increased risk include household contacts of a person known to have has this disease, immunocompromised people, and people traveling to parts of the world where meningococcal meningitis is prevalent.

**How is the meningococcus germ spread?**

The meningococcus germ is spread by direct close contact with nose or throat discharge of an infected person.

**What are the symptoms?**

High fever, headache, vomiting, stiff neck and a rash are symptoms of Meningococcal Disease. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. Among people who develop Meningococcal Disease, 10-15% dies, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

**What is the treatment for Meningococcal Disease?**

Antibiotics, such as penicillin G or certriaxone can be used to treat people with Meningococcal Disease.

**Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated?**

Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventative treatment. Such people are usually advised to obtain a prescription for a special antibiotic (rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

**Is there a vaccine to prevent meningococcal meningitis?**

In February 2005 the CDC recommended a new vaccine, known as Menactra™ for use to prevent Meningococcal Disease in people 11-55 years of age. The previously licensed version of this vaccine, Menomune™ is available for children 2-10 years old and adults older than 55 years. Both vaccines are 85% to 100% effective in preventing the 4 kinds of the meningococcus germ (types A, C, Y W-135). These4 types cause about 70% of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of Meningococcal Disease.

**Is the vaccine safe? Are there adverse side effects to the vaccine?**

Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness at the injection site lasting up to two days.

**Who should get the meningococcal vaccine?**

The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers and travelers to endemic areas of the world.

**What is the duration of protection from the vaccine?**

Menomune™, the older vaccine, requires booster doses every 3 to 5 years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster does.

**How do I get more information about Meningococcal Disease?**

Contact your physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncidod/diseases/index.htm; and the American College Health Association, www.acha.org

Revised: December 2010

# MENINGOCOCCAL MENINGITIS VACCINATION FORM 2012

## CAMP OLMSTED

**475 Riverside Drive, Room 1922**
**New York, NY 10115**
**Telephone: (212) 870-3084**

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.

Parent Signature: ______________________________________ Date: __________

Camper's Name: _________________________________ Date of Birth: __________

Mailing Address: _________________________________________________________

Parent/Guardian's E-mail address (Optional): _________________________________

# SCHOLARSHIP APPLICATION FORM 2012

## *Camp Olmsted*

*475 Riverside Drive, Room 1922, New York, NY 10115*
*(212) 870-3084*

**Scholarships will be awarded on a first come, first serve basis to qualified families beginning January 30th. Applications will be accepted until April 18th. Please note scholarship applications will not be reviewed until all required documents have been submitted.**

**In order to be considered for a scholarship (partial or full) for Camp Olmsted you must submit the following documents in addition to this form:**

- **Copy of most recent tax forms (forms for year 2011 are preferred);**
- **W2 Form(s) for 2011;**
- **Three consecutive pay stubs; and**
- **Complete the attached USDA eligibility form**

Scholarship awards are based on gross income figures as reported on your W2 and 1040 tax forms. Persons who do not have W2 forms must submit official documentation demonstrating their source of income. Persons who are not employed will need to submit unemployment award statements or SSI award letters.

*Required Fields

***Child/Children Name**______________________________

***Session** ______________ **Date Submitted** ______________

***Mother's Name**______________ ***Occupation**______________

**Company**______________ **Work Phone**______________

**Father's Name**______________ **Occupation**______________

**Company**______________ **Work Phone**______________

***Total # of people in household**________ ***Total Household Income $**______________

| *Household Member | *Annual Income | *Source of Income |
|---|---|---|
| | | |
| | | |
| | | |

**Please discuss any additional circumstances you would like us to consider in the evaluation of your application (attach additional sheet if necessary):**

______________________________

______________________________

**Parent/Guardian Signature**______________________________

**Relationship to Child**______________ **Date**______________

www.campolmsted.org

***Office Use Only***

Scholarship Amount Approved $__________________ Source of Scholarship: _________________

Total amount to be paid per child $_______________ USDA Eligible: ☐ Yes ☐ No

Approved by: ____________________________________ Date: ________________

**CAMP OLMSTED**
**475 RIVERSIDE DRIVE, SUITE 1922**
**NEW YORK, NY 10115**
**Telephone: (212) 870-3084**
**Fax: (212) 870-3091**

Summer 2012

Dear Parent/Guardian:

Five Points Mission is participating in the Summer Food Service Program. Meals will be provided free of charge to all eligible children during their enrolled session at amp Olmsted. To be eligible to receive free meals at camp, children must meet the income guidelines for reduced price meals in the National School Lunch Program. Children who are part of households that receive food stamps or benefits under the Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance to Needy Families (TANF) are automatically eligible to receive free meals. The following 2011-2012 income eligibility standards will be used for determining eligibility for free meals:

| Household Size | Annual | Monthly | Weekly |
|---|---|---|---|
| 1…………… | $20,147 | $1,679 | $388 |
| 2…………… | $27,214 | $2,268 | $524 |
| 3…………… | $34,281 | $2,857 | $660 |
| 4…………... | $41,348 | $3,446 | $796 |
| 5…………… | $48,415 | $4,035 | $932 |
| 6…………… | $55,482 | $4,624 | $1,067 |
| 7…………… | $62,549 | $5,213 | $1,203 |
| 8…………… | $69,616 | $5,802 | $1,339 |
| For each additional Family member, add | $7,067 | $589 | $136 |

*Acceptance and participation requirements for the program and all activities are the same for all regardless of race, color, national origin, gender, age or disability, and there will be no discrimination in the course of the meal service. Meals will be provided at the site and times as follows:*

| Name and Address of Site(s) | Meal(s) | Serving Time(s) | Meal Service Dates |
|---|---|---|---|
| Camp Olmsted | Breakfast | 8:15 a.m. | 6/25/12 – 7/6/12 |
| 114 Bay View Avenue | Lunch | 12:15 p.m. | 7/9/12 – 7/27/12 |
| Cornwall-on-Hudson, NY 12520 | Dinner | 6:15 p.m. | 7/30/12 – 8/10/12 |
| | Snacks | 2:45p.m. | 6/25/12 – 8/10/12 |

***Please fill out and return an "Application for Free and Reduced Price School Meals/Milk."***

***Persons interested in receiving more information should contact:***
Five Points Mission 475 Riverside Drive, Room 1922 New York, NY 10115. Telephone: (212) 870-3084.

**Any person who believes he or she has been discriminated against in any USDA-related activity should write or call immediately to: USDA, Director, Office of Civil Rights, Room 326-W. Whitten Building, 1400 Independence Avenue S.W., Washington, DC 20250-9410 or call (800) 785-3272 (voice) or (202) 720-6382 (TTY).**

______________________________________________

(Signature of Authorized Representative) (Date)

# INCOME ELIGIBILITY FORM FOR THE SUMMER FOOD SERVICE PROGRAM

**(For Use by Camps and Closed Enrolled Sites)**

Please complete the following form using the instructions below. Sign the form and return it to: **[Name of Sponsor]** ________________________________________________________________________________________.

If you need help, call **[phone number of Sponsor]**

**Follow these instructions, if your household gets SNAP TANF or FDPIR:**

**Part 1:** List participant's name and a SNAP, TANF or FDPIR case number.
**Part 2:** Skip this part.
**Part 3:** Skip this part.
**Part 4:** Sign the form. A Social Security Number is NOT required.
**Part 5:** Answer this question if you choose to.

**If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:**

**Part 1:** Enter the child's name.
**Part 2:** Please contact us at **[phone number of Sponsor]**
**Part 3:** Complete this part if you are applying for other children in the household and you did not enter a SNAP, TANF or FDPIR case number in Part 1.
**Part 4:** Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.
**Part 5:** Answer this question if you choose to.

**ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:**

**Part 1:** List each participant's name.
**Part 2:** Skip this part.
**Part 3:** Follow these instructions to report total household income from last month.

**Column A–Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B–Gross income last month and how often it was received**. Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In box 2, list the amount each person got last month from welfare, child support, alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

**Column C–Check if no income:** If the person does not have any income, check the box.

**Part 4:** An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
**Part 5:** Answer this question if you choose to.

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to *USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410* or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

**Part 1. Children enrolled in Camp or Closed Enrolled Sites.**

| Names (First, Middle Initial, Last) | SNAP, TANF or FDPIR case # (if any). **Skip to Part 4 if you listed a case #.** |
|---|---|
| | |
| | |
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| | |

**Part 2. Foster Child**

Foster children who are the legal responsibility of a welfare agency or court are eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact **[name of Sponsor]** at **[phone number]**. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP, TANF or FDPIR case number in Part 1.

**Part 3. Total Household Gross Income—You must tell us how much and how often**

| **A. Name** (List **everyone** in household, including children) | **B. Gross income and how often it was received** *Example: $100/monthly $100/twice a month $100/every other week $100/weekly* | | | | **C. Check if NO income** |
|---|---|---|---|---|---|
| | 1. Earnings from work before deductions | 2. Welfare, child support, alimony | 3. Social Security, pensions, retirement, | 4. All Other Income | |
| | $______/________ | $______/_______ | $______/_______ | $______/_______ | ❑ |
| | $______/________ | $______/_______ | $______/________ | $______/_______ | ❑ |
| | $______/________ | $______/_______ | $______/________ | $______/_______ | ❑ |
| | $______/________ | $______/_______ | $______/________ | $______/_______ | ❑ |
| | $______/________ | $______/_______ | $______/________ | $______/_______ | ❑ |
| | $______/________ | $______/_______ | $______/________ | $______/_______ | ❑ |
| | $______/________ | $______/_______ | $______/________ | $______/_______ | ❑ |
| | $______/________ | $______/________ | $______/________ | $______/________ | ❑ |
| | $______/________ | $______/________ | $______/________ | $______/________ | ❑ |
| | $______/________ | $______/________ | $______/________ | $______/________ | ❑ |
| | $______/________ | $______/________ | $______/________ | $______/________ | ❑ |
| | $______/________ | $______/_______ | $______/________ | $______/_______ | ❑ |

**Part 4. Signature and Social Security Number (Adult must sign)**

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

*I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: X________________________________Print name:_______________________________Date: ______________

Address:___________________________________________________________Phone Number:_______________________

Last four digits of Social Security Number: __ __ __ __ ❑ I do not have a Social Security Number

**Part 5. Participant's ethnic and racial identities (optional)**

| Mark one ethnic identity: | Mark one or more racial identities: | |
|---|---|---|
| ❑ Hispanic or Latino<br>❑ Not Hispanic or Latino | ❑ Asian<br>❑ White<br>❑ Black or African American | ❑ American Indian or Alaska Native<br>❑ Native Hawaiian or Other Pacific Islander |

**Don't fill out this part. This is for official use only.**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: ____________ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year

Household size: ________

Categorical Eligibility: ___ Date Withdrawn: ________ Eligibility: Free___ Reduced___ Denied___

Reason: ____________________________________________________________________________________

Determining Official's Signature: ________________________________________________ Date: ______________

Confirming Official's Signature: _________________________________________________ Date: ______________

Follow-up Official's Signature: __________________________________________________ Date:______________