OLMSTED DAY CAMP

JOIN THE FUN!

DON'T MISS OUT –

REGISTER NOW FOR SUMMER 2012!

BOYS AND GIRLS AGES 6-13

****9AM – 5:45PM**

*****EARLY DROP-OFF AND LATE PICK-UP AVAILABLE!***

A VARIETY OF ACTIVITIES TO APPEAL TO THE ARTIST, THE ATHLETE, THE CHEF, THE WRITER…

SAMPLE ACTIVITY SCHEDULE

9:00 AM	ARTS & CRAFTS
10:00 AM	HOBBY HUT (ARTS & CRAFTS)
11:00 AM	INSTRUCTIONAL SWIM
12:15 PM	LUNCH (USDA APPROVED)
1:00 PM	REST PERIOD (LOW ENERGY ACTIVITIES)
2:00 PM	ROPES CHALLENGE COURSE
3:00 PM	KIDS' KITCHEN
4:00 PM	FREE SWIM
5:00 PM	COMPUTER LAB
5:45 PM	PICK-UP

For registration information or to find out Open House dates…
CALL: (845) 534-7900 EXT. 11
EMAIL: olmstedctr@aol.com
VISIT: www.campolmsted.org

CAMP OLMSTED
Summer Day Camp 2012

AGES 6 - 13

WEEK	CAMP DATES	REGISTRATION DEADLINE	FIRST CHILD	SIBLING RATE
1	June 25 – June 29	June 11	$135	$115
2	July 2-5 *No camp on Friday.*	June 18	$110	$95
3	July 9-13	June 25	$135	$115
4	July 16-20	July 2	$135	$115
5	July 23-26 *No camp on Friday.*	July 9	$110	$95
6	July 30-August 3	July 16	$135	$115
7	August 6-9 *No camp on Friday.*	July 23	$110	$95
TOTAL FOR 7 WEEKS			$870	$745

ADD $25 REGISTRATION FEE PER CHILD

All forms and final payments are due the Monday <u>two weeks prior</u> to the start of the session.

Registration is not guaranteed until full payment and all forms have been received.

A refund (excluding the $25 registration fee) is available
for cancellation made a minimum of 14 days in advance.

REGULAR DAY CAMP HOURS: 8:45 AM – 5:45 PM

EXTENDED HOURS ARE AVAILABLE FOR AN ADDITIONAL $25/WEEK/CHILD/OPTION

<u>EXTENDED-DAY OPTIONS</u>

EARLY DROP-OFF: 7:45 AM – includes BREAKFAST - $25/child/week

LATE PICK-UP: 6:00 PM to 7:00 PM – after 6:30 includes DINNER - $25/child/week

TO RECEIVE REGISTRATION MATERIALS

CALL: (845) 534-7900 EXT. 11

EMAIL: OLMSTEDCTR@AOL.COM

VISIT: WWW.CAMPOLMSTED.ORG

FIVE POINTS MISSION

CAMP OLMSTED

olmstedctr@aol.com www.fivepoints.org

845.534.7900

Olmsted Center's Camper Release Policy

Anyone picking up a child from camp must sign the camper out on the sign-out sheet in the camp office. Camp staff may ask to see identification to verify the person is permitted to pick up the child.

Campers will be released only to parents/guardians and emergency contacts listed on the camper application. In the event the parent/guardian or emergency contact is unable to pick up the child(ren), a letter signed by the parent/guardian must be submitted to the camp office prior to the pick-up or be faxed to Olmsted Center - (845) 534-3540, authorizing the named individual to pick up the child.

Special permission for Camper Release

I give permission for my child ____

to be picked up by ____

Name of Adult **Relationship to Camper**

on ____.

Date (month, day, year)

I understand that this permission is good only for the dates stated above.

________________________________ __________________

Parent's Signature **Date**

PO BOX 291 . 114 BAY VIEW AVENUE . CORNWALL ON HUDSON . NEW YORK . 12520

Camp Olmsted Day Camp 2012
Registration Form

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)______

Preferred t-shirt Size (circle one) - Child: M L Adult: S M L XL

Camp Weeks Requested:

☐ Week 1: June 25 – June 29 ☐ Week 2: July 2 – July 5 ☐ Week 3: July 9 – July 13 ☐ Week 4: July 16 – July 20

☐ Week 5: July 23 – July 26 ☐ Week 6: July 30 – August 3 ☐ Week 7: August 6 – August 9

Special requests:

☐ Early Drop-off (additional $25/week) Time _________AM ☐ Late Pick-up (additional $25/week) Time _________PM

Who is responsible for bringing and picking up your child?_______________________Relationship:_________________

If you would like for your child to walk home or be picked up by someone other than the above named, you must give written permission.

FAMILY DATA - *For phone numbers, please circle Home, Work or Cell.*

Mother's Name_____________________________________ Phone (_________)_____________________ (H / W / C)
☐ Check box if child lives with this person. Phone (_________)_____________________ (H / W / C)

Father's Name_____________________________________ Phone (_________)_____________________ (H / W / C)
☐ Check box if child lives with this person. Phone (_________)_____________________ (H / W / C)

Foster Parent_____________________________________ Phone (_________)_____________________ (H / W / C)
☐ Check box if child lives with this person. Phone (_________)_____________________ (H / W / C)

Guardian's Name___________________________________ Phone (_________)_____________________ (H / W / C)
☐ Check box if child lives with this person. Phone (_________)_____________________ (H / W / C)

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 ASSSISTANCE INFORMATION – *if applicable*

AFDC # ____ IM CENTER____

HEALTH INSURANCE DATA

Insurance Carrier ____ Group/Plan # ____

ID or Policy # ____ Medicaid # ____

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

Parent Comments

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

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

Is you child a vegetarian? ☐ No ☐ Yes Vegan? ☐ No ☐ Yes

Any allergies, besides food? ____

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 you child handle conflicts with other children? ____

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

____

Are you a member of the Methodist Church? (Optional) ☐ No ☐ Yes If yes, which one? ________________________
(for data purposes only)

FOR THE PARENT

1. I have read and understand Camp Olmsted's 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 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 Name ______ First ______ Middle ______ Last ______ (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
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

General Health History: ***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.

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)? …………………………....... ☐ 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.

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.

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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) ______________________________

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

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

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 ❒

www.campolmsted.org

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)

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