



Camp Harkness Summer 2009

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Registration Procedure & Timeline

It is suggested to complete paperwork and submit in stages, rather than wait for all pages to be completed.

It is also suggested that you make a copy of **ALL** forms for your record. It is recommended that you bring your copy with you on registration day to ensure an easy admission to camp.

Step 1: Complete Ability & Adjustment, Skills Checklist, and Water Safety Skill Assessment forms

Please fill out these forms immediately and return to The Arc of New London County.

Step 2: Complete Medical Forms

Each camper is required to submit an updated physical annually. The Camp Harkness Medical Form must be signed by a **Connecticut physician** within one year of attending camp. These forms **MUST** be submitted to The Arc ***two weeks before the camper is scheduled to attend camp.***

Step 4: Complete Packet Information

Please carefully review and complete the remainder of the forms in your packet and send as soon as possible. Note the special instructions listed on the Table of Contents. The remainder of Packet Information (except the clothing inventory which should be sent with the camper on registration day) is due ***two weeks before the camper is scheduled to attend camp.***

Step 5- Payment Balance

Please make full payment made out to **The Arc of New London County.** Campers will not be admitted unless full payment has been made prior to their arrival.

Submit all Forms and Payment to:

Arc of New London County Tel: (860) 822-0801
Attn: Jen Hickey Fax: (860) 889-4662
125 Sachem Street
Norwich, CT 06360

A prompt turnaround of these forms and payment of balance will reduce delays on registration day. ***Failure to submit forms may affect the camper's stay at camp.***

*** Please read reverse side.**

Registration Procedure & Timeline (continued)

Arrival & Departure Times:

Camper Arrival Time: **Sundays, 2:00 - 4:00 pm**

NO ONE IS ALLOWED TO UNLOAD OR PARK IN THE CABIN AREA UNTIL 2:00 PM. Campers who arrive early will be asked to visit the beach or other surrounding areas. Please cooperate and allow the staff to finish preparations prior to arrival.

Camper Departure Time: **Fridays, 2:00 - 4:00 pm**

No Medications will be administered after 12:30 pm. It is crucial that campers are picked up BEFORE 4:00 pm, as no meals will be provided after lunch. Failure to pick up campers on time will result in additional charges.

Check-In:

Registration will take place in the stone building located in the yellow cabin area. Consult the enclosed map and signs within the park for accurate directions. **ALL PROVIDERS** must first register with the Camp Director. In addition, all providers dropping off medication **MUST** meet with the camp nursing staff.

Discharge & Refunds:

Camper Director reserves the right to discharge campers at any time.

Refund Policy: No refund of camp fees will be made in connection with the following circumstances: failure to attend scheduled session, late cancellations (refundable cancellations must be made at least one week prior to the start of the camper's session), late arrivals, early withdrawals, or dismissal due to misconduct. If a camper is scheduled for two weeks, he/she will not be refunded for the second week if they are sent home for misconduct or homesickness.

An exception to this policy may be made for campers who are unable to attend due to physical illness or injury. The camper must produce documentation from a physician or nurse certifying that he or she is unable to participate in camp activities. Campers who arrive late or leave early due to injury or illness will receive pro-rata refunds only. Homesickness is not considered as a basis for a refund.

Camp Information:

While campers are at camp you should address letters to:

Camp Harkness-ARC
301 Great Neck Rd
Waterford, CT 06385

Camp Tel: (860) 437-0636
Camp Fax: (860) 442-3811
Camp Director: Jen Hickey

**Note the camp office phone and fax will not be set up until June 12, 2009.
Until that time contact Jen Sullivan Hickey at (860)822-0801.**

Schedule & General Information

Please review the following schedule carefully as the sessions have changed:

| Session # | Dates |
|---|---|
| Session 1 (One Week) | Begins: Sunday, June 21 @ 2:00pm Ends: Friday, June 26 @ 4:00pm |
| Intercession: No campers Friday, June 26 thru Saturday, June 27 | |
| Session 2 (One Week) | Begins: Sunday, June 28 @ 2:00pm Ends: Friday, July 3 @ 4:00pm |
| Intercession: No campers Friday July, 3 thru Saturday, July 4 | |
| Session 3 (One Week) | Begins: Sunday, July 5 @ 2:00pm Ends: Friday, July 10 @ 4:00pm |
| Intercession: No campers Friday, July 10 thru Saturday, July 11 | |
| Session 4 (One Week) | Begins: Sunday, July 12 @ 2:00pm Ends: Friday, July 17 @ 4:00pm |
| Intercession: No campers Friday, July 17 thru Saturday, July 18 | |
| Session 5 (One Week) | Begins: Sunday, July 19 @ 2:00pm Ends: Friday, July 24 @ 4:00pm |
| Intercession: No campers Friday, July 24 thru Saturday, July 25 | |
| Session 6 (One Week) | Begins: Sunday, July 26 @ 2:00pm Ends: Friday, July 31 @ 4:00pm |
| Intercession: No campers Friday, July 31 thru Saturday, August 1 | |
| Session 7 (One Week) Residential Youth Week ages 8-21 | Begins: Sunday, August 2 @ 2:00pm Ends: Friday, August 7 @ 4:00pm |
| Intercession: No campers Friday, August 7 thru Saturday, August 8 | |
| Session 8 (One Week) Day Camp Youth Week ages 8-21 | <u>Day Hours 8:00 am – 5:00 pm</u> Begins: Sunday, August 9 - 1:00 pm – 4:00 pm Monday – Thursday 8:00 am – 5:00 pm Ends: Friday, August 14 – 8:00 am – <u>2:00 pm</u> |

Emergency Contact Sheet

Camper Name: _____

Please make sure that the person(s) listed on this form are aware that they are responsible for your camper in the event of an emergency (medical or behavioral) during the camper's stay.

Fill in ALL appropriate areas. Numbers should be DIFFERENT. If the number is an office number, please include a different number to contact people outside the regular office hours.

| | |
|---------------------------|--|
| Name | |
| Relation | |
| Home Phone | |
| Work/Daytime Phone | |
| Cell Phone | |
| Pager | |
| Fax | |
| Other | |

If the person listed above is not available, contact:

| | |
|---------------------------|--|
| Name | |
| Relation | |
| Home Phone | |
| Work/Daytime Phone | |
| Cell Phone | |
| Pager | |
| Other | |

Comments: _____

Camp Harkness Authorizations Form

Applicant Name: _____

Please note: All areas require your review and signature before the camper will be admitted.

Consent for Medical, Surgical, or Dental Treatment

I hereby give permission to the Director and/or Medical Personnel of Arc of New London County to authorize emergency medical, surgical, or dental treatment, for the applicant including administration of medications, immunizations, and anesthesia in a community hospital, clinic, nursing facility, or private office if considered necessary or desirable by a physician or dentist.

X _____
Signature of applicant, parent, or legal guardian Date

Activities Consent

I give permission for applicant to participate in all planned activities and trips of the agency.

X _____
Signature of applicant, parent, or legal guardian Date

Photo Release

I give permission to the agency to photograph the applicant. I understand that the photograph may be used for educational purposes, agency publications, and/or postings on the agency web site. In addition, photos may be also be used for the public information through the news media.

Yes____ No____

X _____
Signature of applicant, parent, or legal guardian Date

Please Note: A photo of the camper will be taken and kept on file for medical and identification purposes. This will be used by the camp nurse to positively identify the camper for medication administration. The above release relates to other photos which may be taken in the course of the camper's stay.

Release of Medical Information

I give permission to the agency to access all medical information relevant to the applicant's health and safety during his or her stay at camp. This includes information on the attached medical forms as well as phone conversations and/or correspondence subsequent to registration. All information will be kept confidential and will be used for legitimate purposes by our medical staff only.

X _____
Signature of applicant, parent, or legal guardian Date

Please note that the Arc of New London County is subject to the regulations set forth in the Health Insurance Portability and Accountability Act (HIPPA). You are entitled to review a copy of our Notice of Privacy Practices. If you wish to do so, please contact our Privacy Officer at 860-889-4435.

Camp Harkness Medical Standard

Important: Please review the following information carefully. Failure to comply with any one of these standards could result in your camper being sent home.

- 1) A completed Camp Harkness Medical Form with a Connecticut doctor's signature is required within one year of attendance at camp.
- 2) Diagnosis and pertinent medical information must be listed.
- 3) Must have tetanus booster within last ten years.
- 4) Authorizations for medical, surgical and dental treatments must be signed.
- 5) **All medications must have written orders signed by a physician.** When changes are made after medical forms are completed and sent, an updated written order signed by a physician must be sent to The Arc prior to camp attendance.
- 6) Medication must be in the original containers from the pharmacy with proper labels. **Do not put medication in individual envelopes or pill boxes**, even if the camper self medicates.
- 7) **Sufficient medication and supplies** are a must for the entire stay of the camper. This includes all medications, syringes, diabetic testing and personal items.
- 8) Medication will be administered at the following intervals:

AM- 8:00 am
Noon-12:30 pm
Dinner- 6:00 pm
Hour of Sleep- 9:00 pm

Insulin ½ Hour before meals. Testing as ordered.

- 9) Camp Harkness has its own records for administration of medication, narcotic sheets, etc. Please do not ask the organization nurses to sign off your home or hospital records. Copies of our forms will be provided when medication is returned on check out day.
- 10) All campers must give medication to nurse to be locked in the infirmary.
- 11) All adaptive equipment must be provided by the camper and should be in good repair. This includes braces, wheelchairs, crutches with extra tips, talking boards, feeding utensils, etc.
- 12) A doctor's order is needed for mechanical restraint of the campers in wheelchairs or beds, including bedrails and pads.
- 13) Communicable diseases such as athlete's foot, ringworm, "pink-eye", etc. will lead to the camper being sent home, unless a doctor's certificate accompanies the camper regarding treatment and states the camper is not contagious. **To minimize the spread of infectious diseases, any/all infected camper(s) will be sent home.**
- 14) We do not provide special diets other than ground or puree.
- 15) Camp Harkness maintains contracts for medical services with a local physician's group as well as Lawrence & Memorial Hospital in New London, CT.

In order to keep the number of medications to a minimum, please discontinue all nonessential medications (i.e. Vitamins, creams, and ointments) for the duration of the camper's stay.

Camp Harkness Medical Form

Complete ALL areas. Incomplete forms will be returned!

Camper Name: _____ Sex: _____ Age: _____ DOB: _____

Camper Address: _____ DMR # _____

_____ Social Sec #: _____

Insurance Co. and Number: _____

Emergency Contact: _____ Relationship to Camper: _____

Emergency Contact Tel: (_____) _____

The following must be completed by a Connecticut physician within one year of camping:

Diagnosis and pertinent information: _____

Allergies: _____

Required Adaptive Equipment: (braces, utensils, etc.) _____

Does Camper Require Bedrails? Yes _____ No _____ Does Camper Require Bedrail Pads? Yes _____ No _____

Camper must supply own bed rail pads.

| | | | | | | | | | | | |
|--|--|---------------------------|--|--|--|------------------|--|--------------------------|--|---------------|--|
| Height | | Weight | | BP | | Heart | | Lungs | | Extremities | |
| Teeth | | Skeletal | | Abdomen | | Genitalia | | Throat | | Hernia | |
| Diabetes: Yes _____ No _____ | | Controlled by Diet: _____ | | Oral: _____ | | Injection: _____ | | | | | |
| Seizures: Yes _____ No _____ | | Type: _____ | | Frequency: _____ | | | | | | | |
| Asthma: Yes _____ No _____ | | | | Immunizations Complete: Yes _____ No _____ | | | | | | | |
| Special Diet: Ground _____ | | Puree _____ | | Liquid Consistency: Thin _____ | | Nectar _____ | | Honey _____ | | pudding _____ | |
| List Chronic/Recurring Illnesses: | | | | | | | | | | | |
| Earaches | | Sinus | | Throat | | Stomach | | Date last Tetanus: _____ | | | |
| Hypertension | | Cardiac | | URI | | Menstrual | | | | | |
| Other (Specify) | | | | | | | | | | | |
| | | | | | | | | | | | |
| Restraints: Yes _____ | | No _____ | | Specify Reason and Kind: | | | | | | | |
| | | | | | | | | | | | |

**** Complete and sign reverse side***

Medication Orders- Must be completed and signed by physician

Camper Name: _____

Discontinue all nonessential *vitamins*, creams, and ointments for the duration of the camper's stay.

Special Needs Rates will be applied if TOTAL medications exceed ten medications.

Completed orders must include dose, route and interval.

Campers will not be admitted if this information is missing or unclear.

| # | Drug Name | Dose | Route | Interval | | | |
|-----------------------|-----------|------|-------|----------|------|-----|----|
| | | | | AM | Noon | Din | HS |
| 1 | | | | | | | |
| Special Instructions: | | | | | | | |
| 2 | | | | | | | |
| Special Instructions: | | | | | | | |
| 3 | | | | | | | |
| Special Instructions: | | | | | | | |
| 4 | | | | | | | |
| Special Instructions: | | | | | | | |
| 5 | | | | | | | |
| Special Instructions: | | | | | | | |
| 6 | | | | | | | |
| Special Instructions: | | | | | | | |
| 7 | | | | | | | |
| Special Instructions: | | | | | | | |
| 8 | | | | | | | |
| Special Instructions: | | | | | | | |
| 9 | | | | | | | |
| Special Instructions: | | | | | | | |
| 10 | | | | | | | |
| Special Instructions: | | | | | | | |

Physician's Signature: _____

Date: _____

Physician's Name (please print) _____

Address: _____

Tel: _____

Camp Harkness Physician's Standing Order Sheet

Important: The following Standing Orders are established to provide Medical Personnel directions to treat minor health conditions. When standing orders are used, the staff will document appropriately.

In all cases: if symptoms persist, notify camp medical personnel or outside physician for further instruction.

Please modify doses for youth campers (ages 8-18) if necessary.

Camper Name: _____

Date last tetanus: _____

List allergies: _____

| | | | | | | | | | | | | | | | | | | | | | |
|--|-------------------------------|---|-----------------------|---|-------------------------------|---|--------------|--|--------------------|---|---|-------------------|---|---|---|---|--|---|---|----------------------------------|---|
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Abrasion or Laceration</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Clean with soap and water and remove debris 2. Apply antibiotic cream topically 3. Cover with dry sterile dressing 4. Repeat until healed </td> </tr> <tr> <td style="text-align: center;">Athlete's Foot</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Antifungal cream or powder BID topically 2. Review in two (2) weeks for effectiveness </td> </tr> <tr> <td style="text-align: center;">Bee Sting Insect Bites</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Apply cool compress for pain and swelling 2. Observe for allergic reaction 3. Seek medical treatment at Emergency Room if necessary 4. Utilize Epi-Pen if necessary </td> </tr> <tr> <td style="text-align: center;">Burns</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Flush with cold water 2. Observe for blisters/infections 3. Report to physician accordingly </td> </tr> <tr> <td style="text-align: center;">Human Bites</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Cleanse with soap and water 2. Check tetanus status 3. Call MD or seek medical treatment </td> </tr> </table> | Abrasion or Laceration | <ol style="list-style-type: none"> 1. Clean with soap and water and remove debris 2. Apply antibiotic cream topically 3. Cover with dry sterile dressing 4. Repeat until healed | Athlete's Foot | <ol style="list-style-type: none"> 1. Antifungal cream or powder BID topically 2. Review in two (2) weeks for effectiveness | Bee Sting Insect Bites | <ol style="list-style-type: none"> 1. Apply cool compress for pain and swelling 2. Observe for allergic reaction 3. Seek medical treatment at Emergency Room if necessary 4. Utilize Epi-Pen if necessary | Burns | <ol style="list-style-type: none"> 1. Flush with cold water 2. Observe for blisters/infections 3. Report to physician accordingly | Human Bites | <ol style="list-style-type: none"> 1. Cleanse with soap and water 2. Check tetanus status 3. Call MD or seek medical treatment | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Groin Rash</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Zinc oxide to be applied PRN for groin rash topically 2. Must wash and dry well between application </td> </tr> <tr> <td style="text-align: center;">Diarrhea (After 2nd incident)</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Clear liquids X 24 to 48 Hours 2. Hold stool softeners X 24 Hours 3. No fruit juices 4. Monitor intake and output 5. Call MD if diarrhea persists 6. Imodium AD </td> </tr> <tr> <td style="text-align: center;">Elevated Temperature Above 101 degrees</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Tylenol 500mg PO or PR Q 4 Hrs PRN X 24 Hrs 2. Force fluids 3. TPR Q 4 Hrs X 48 Hrs 4. Call MD if Temperature persists </td> </tr> <tr> <td style="text-align: center;">C/O Headache, General Discomfort</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. Tylenol 500mg PO or PR Q 4 Hrs PRN X 24 Hrs 2. Observe for additional symptoms 3. Report to MD if condition persists </td> </tr> <tr> <td style="text-align: center;">Complaints of Indigestion</td> </tr> <tr> <td> <ol style="list-style-type: none"> 1. 2 Tbsp of Mylanta PO PRN Q 4 Hrs 2. Limit to 3 doses in 24 Hrs 3. If pain persists, seek medical treatment </td> </tr> </table> | Groin Rash | <ol style="list-style-type: none"> 1. Zinc oxide to be applied PRN for groin rash topically 2. Must wash and dry well between application | Diarrhea (After 2nd incident) | <ol style="list-style-type: none"> 1. Clear liquids X 24 to 48 Hours 2. Hold stool softeners X 24 Hours 3. No fruit juices 4. Monitor intake and output 5. Call MD if diarrhea persists 6. Imodium AD | Elevated Temperature Above 101 degrees | <ol style="list-style-type: none"> 1. Tylenol 500mg PO or PR Q 4 Hrs PRN X 24 Hrs 2. Force fluids 3. TPR Q 4 Hrs X 48 Hrs 4. Call MD if Temperature persists | C/O Headache, General Discomfort | <ol style="list-style-type: none"> 1. Tylenol 500mg PO or PR Q 4 Hrs PRN X 24 Hrs 2. Observe for additional symptoms 3. Report to MD if condition persists | Complaints of Indigestion | <ol style="list-style-type: none"> 1. 2 Tbsp of Mylanta PO PRN Q 4 Hrs 2. Limit to 3 doses in 24 Hrs 3. If pain persists, seek medical treatment |
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| <ol style="list-style-type: none"> 1. Clean with soap and water and remove debris 2. Apply antibiotic cream topically 3. Cover with dry sterile dressing 4. Repeat until healed | | | | | | | | | | | | | | | | | | | | | |
| Athlete's Foot | | | | | | | | | | | | | | | | | | | | | |
| <ol style="list-style-type: none"> 1. Antifungal cream or powder BID topically 2. Review in two (2) weeks for effectiveness | | | | | | | | | | | | | | | | | | | | | |
| Bee Sting Insect Bites | | | | | | | | | | | | | | | | | | | | | |
| <ol style="list-style-type: none"> 1. Apply cool compress for pain and swelling 2. Observe for allergic reaction 3. Seek medical treatment at Emergency Room if necessary 4. Utilize Epi-Pen if necessary | | | | | | | | | | | | | | | | | | | | | |
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Complete and sign reverse side!

| Constipation |
|---|
| <ol style="list-style-type: none"> 1. Dulcolax Supp. PR on 3rd day if no BM 2. Fleet on 4th day if no BM 3. If no result, seek medical attention |

| Rashes (Generalized) |
|--|
| <ol style="list-style-type: none"> 1. Apply Cortisone Cream 0.5% topically to affected area 3 times daily X 72 Hrs 2. Call MD if rash persists |

| Contusions |
|---|
| <ol style="list-style-type: none"> 1. Cool compress X 15 Minutes |

| Runny Nose |
|--|
| <ol style="list-style-type: none"> 1. Dimetapp Elixir * 5cc PO Q 4 Hrs X 48 Hrs <p>List RX Alternative:</p> |

| Vomiting |
|---|
| <ol style="list-style-type: none"> 1. NPO X 2 Hrs Then: 2. Clear liquids slowly as tolerated (Jell-O, ice pops, 7-Up, Ginger Ale, Kool Aid) 3. No Tea, Coke, or coffee 4. If condition persists, notify MD 5. Monitor intake and output 6. VS of shift X 24 |

| Sunburn (use sunscreen 20 and above) |
|---|
| <ol style="list-style-type: none"> 1. Mild to Moderate: Cool Compress 2. Blisters: Call MD / Seek medical treatment |

| Menstrual Cramps (choose one of the listed medications below) |
|---|
| <ol style="list-style-type: none"> 1. Advil 2 Tabs Q 4 Hrs 2. Midol 2 Tabs Q 4 Hrs 3. Pamprin 2 Tabs Q 4 Hrs <p>List RX Alternative:</p> |

The preceding orders will be in effect from: _____ To: _____
 (May be substituted for generic brands)

 Physician's Signature

 Date

Address: _____

Tel: _____

****PPA has been removed from these products per Medical Pharmacy***

Proof of Immunization (Youths Only)

This form must be completed for all campers who are under the **age of 18** during their stay at camp. Adults do not need to fill out this form.

Camper Name: _____ Date of Birth: _____

Immunization Record: (Month, Day, Year for each dose)

| Immunization | Date | | | | | Immunization | Date |
|------------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|---|------|
| | 1 st Dose | 2 nd Dose | 3 rd Dose | 4 th Dose | 5 th Dose | | |
| DTP / DTaP / DT | | | | | | MMR (1 st Dose) | |
| OPV / IPV | | | | | | Measles (2 nd Dose) | |
| Hob (Haemophilus Influenza Type B) | | | | | | Varicella (Chicken Pox) *Recommended | |
| Hepatitis B | | | | | | Other (Specify) | |

Are there medical contraindications to immunizations? Yes ___ No ___

If yes, specify the vaccine(s) and list the contraindications specified in the manufacturer's package insert that applies: _____

Does this individual have laboratory confirmed proof of immunity to natural infection? Yes ___ No ___

If yes, please explain and attach lab report: _____

Is this individual current or in progress with the immunizations according to the schedule adopted by the Commissioner of Public Health? Yes ___ No ___

Next appointment for immunization is scheduled for: _____
 Month/Day/Year

 Signature of MD, APRN, or PA

 Date Signed

Medical Care Provider (Name, Address, Phone): _____

Skills Checklist

Camper Name: _____

Please complete front AND back!

These forms are used by camp staff to determine level of supervision and assistance provided at camp. Please be as thorough and specific as possible to ensure the health and safety of the camper.

Name of Person Completing form: _____
 Relationship to Camper: _____

Please check level of overall assistance camper requires while at camp.
 Significant _____ Minimal _____ Only with certain activities _____

Self Help Skills

Please place a checkmark in the appropriate column to describe the camper's ability in these areas.

Independent – Ind

Hand-Over-Hand - HH

Verbal Prompting – VP

Total Assistance - Total

| Self Help Skills | Ind. | VP | HH | Total | Comments/Directions |
|--|------|----|----|-------|---------------------|
| Toileting | | | | | |
| Washes Hands | | | | | |
| Brushes Teeth | | | | | |
| Showering | | | | | |
| Apply/Dispose Sanitary Napkins (if applicable) | | | | | |
| Dresses/Undresses | | | | | |
| Ties/Unties shoes | | | | | |
| Eating/Drinking | | | | | |
| Additional Comments: | | | | | |
| | | | | | |
| | | | | | |

Other Needs

Please place a checkmark to indicate any difficulties related to the following areas:

| | | | | |
|--------------|--|--|-------------|--|
| Sleepwalking | | | Wandering | |
| Nightmares | | | Bolting | |
| Incontinence | | | Other Needs | |

WE DO NOT PROVIDE AWAKE STAFF!! ALL campers MUST sleep from 11 pm – 7 am.

Comments regarding checked items:

| |
|--|
| |
| |

Cabin Requests: (optional...not all requests will be granted)

Please try to put these campers in the same cabin with this camper: _____

Please try to put these campers in a different cabin than this camper: _____

Adaptive Equipment

Please check off any required special equipment used by camper. Camper should bring ALL necessary equipment to camp. (Shower chair/bench and bedrails are provided.)

Please note: Any checked items in this section **MUST** appear in the adaptive equipment section on the **front side of the physical form.**

| | | | | |
|---|--|--|--------------------------------|--|
| Wheelchair | | | Hearing Aid | |
| Walker | | | Glasses | |
| Cane | | | Dishes | |
| Crutches | | | Utensils | |
| Braces | | | Bedrails (need doctor's order) | |
| Special Shoes | | | Bedrail Pads (must bring own) | |
| C-Pap Machine at Night | | | Other (Specify Below) | |
| Briefs (size _____) | | | | |
| Comments regarding checked items (please include any assistive technology including computers, talkers, picture books, etc) | | | | |
| | | | | |
| | | | | |

Mobility

Please check if assistance is required in any of the following areas.

| | Yes | No | Comments |
|---|-----|----|------------------------|
| Lifting (Please check one method below which will work best for camper.) | | | |
| Stand and Pivot | | | |
| Two Person Lift | | | |
| Three Person Lift | | | |
| Hoyer Lift | | | (Please provide sling) |
| Walking | | | |
| Additional Comments: | | | |
| | | | |
| | | | |

Please provide any other information pertinent to the overall assistance provided to the camper during the duration of the session.

| |
|--|
| |
| |
| |

Behavior Checklist

Camper Name: _____

Please complete front AND back!

These forms are used by camp staff to determine level of supervision and assistance provided at camp. Please be as thorough and specific as possible to ensure the health and safety of the camper.

Name of Person Completing form: _____

Relationship to Camper: _____

| Social Behavior | Yes | No | Comments |
|---|-----|----|----------|
| Feels secure in new situations but needs reassurance | | | |
| Engages in conversation | | | |
| Expresses needs in sign language | | | |
| Uses understandable speech | | | |
| Interacts safely under group supervision (3:1 ratio) | | | |
| Respects the property of others | | | |
| Appropriately expresses anger or frustration | | | |
| Interacts with others | | | |
| Able to participate/tolerate large group activities (50-125 people) | | | |

| Common Personality Traits | | Comments |
|---|--|----------|
| Please check traits applicable to camper. | | |
| Outgoing/Friendly | | |
| Shy | | |
| Enjoys new experiences | | |
| Needs structure | | |
| Needs encouragement | | |
| Gets along with others | | |
| Prefers to be alone | | |
| List special hobbies or interests | | |
| | | |
| | | |
| List any additional information (problems, attitudes, preferences,) which will assist us in providing a quality stay at camp: | | |
| | | |
| | | |
| | | |
| | | |

Behavioral Concerns

Due to the recreational atmosphere at camp, **we can not accommodate** many physical or aggressive behaviors at camp. To ensure the health and safety of all camp participants, **campers may be sent home even after one behavioral episode.** Please be as thorough and specific as possible in the following sections to help us plan appropriately.

| | |
|---|--------------------|
| Does camper display aggressive behaviors? | Yes _____ No _____ |
| Please fully describe behaviors, including methods used to redirect or stop behaviors. | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| Does camper display self injurious behaviors? | Yes _____ No _____ |
| Please fully describe behaviors, including methods used to redirect or stop behaviors. | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| Additional Safety Concerns? | Yes _____ No _____ |
| Please describe. | |
| | |
| | |
| | |
| The camper will be sleeping in a large common room in the cabin with other campers. Each camper will have his/her own bed. The counselors will be sleeping in a separate room in the cabin. | |
| Does the camper have any current or past behaviors (even just once) which may be exhibited in this living environment? (i.e. taking other's property, inappropriate contact, etc.) | |
| Yes _____ No _____ | |
| Please Describe. | |
| | |
| | |
| | |



IP Addendum: Aquatic Activity Screening

| | | |
|--------------|--------------|--------------|
| Name: | DDS#: | Date: |
|--------------|--------------|--------------|

This screening is in effect for one year from the date on this form as part of the IP or up to three years for individuals with an IP Short Form. Request for any changes or updates to this form must be made through the team process.

SECTION 1: Screening For Presence And Participation in Aquatic Activities

Definitions:

Aquatic Activities: are all water related activities including swimming, boating, fishing, hot tubs, water parks and those activities PROXIMAL TO WATER.

Proximal To Water: aquatic activities are those at any location where there are bodies of water present at the intended destination that are open and accessible to individuals. This means there are no barriers to prevent access such as secure fencing or padlocked gates. Contact with the water may, or may not be intended. Bodies of water include, but are not limited to: streams, creeks, oceans, lakes, ponds, pools, hot tubs, wading pools, natural or man-made water areas or similar. Proximal to water activities include, but are not limited to: picnics in a park where there is water, feeding the ducks at a pond, unrestricted access to backyard wading (or swimming) pools or hot tubs, walks on the beach or similar.

Shallow Water: is defined as water at or below the height of the individual’s chest.

Deep Water: is defined as water above the height of the individual’s chest.

The Planning and Support Team should assign an Aquatic Activity Code “0 to 6 “for the individual

Aquatic Activity Code- * Choose One:

- 0 = Does NOT** swim or participate in ANY aquatic activities. **If coded as “0”, Section 2 should have “NO” checked for all activities listed.**
- 1 = Proximal to Water Activities Only – Must Be With Staff.** Participates only in activities proximal to water as defined above.
- 2 = Shallow Water Only;** limited or no swimming skills. **Does Not Respond** to verbal redirection; may not recognize dangerous situations.
- 3 = Shallow Water Only;** limited or no swimming skills. **Usually Responds** to verbal redirection; may/may not recognize dangerous situations.
- 4 = Deep Water swimmer;** can swim in deep water **with supervising staff**; may have medical or safety needs
- 5 = Independent Deep Water Swimmer;** may go swimming without staff; **AND/OR independently accesses aquatic activities without staff**; may not, or chooses not, to swim. The Water Safety Checklist shall be reviewed annually with the individual to encourage safe aquatic activity participation.
- 6 = Aquatic Activity Level Not Known.** Approved only for aquatic activities as permitted below and **MUST BE IN A ONE-TO-ONE** enhanced individual to staff ratio at all of these activities until code is determined and approved.

SECTION 2: Aquatic Activities and Supervision Needs – Include Staff to Individual Ratio as Appropriate

NOTE: If supervision needs are unknown due to lack of previous participation, the individual must be in a 1:1 enhanced staff to individual ratio at all aquatic activities they are able to participate in, until a safe appropriate ratio can be determined and approved.

(Shaded areas Not Applicable to Camp)

| Aquatic Activity | Able to Participate | Individual Supervision: Needs: 3:1, 2:1, 1:1 | Comments (needs lifejacket, medical information, etc.) |
|--|--|--|--|
| Activities Proximal to Water | <input type="checkbox"/> yes <input type="checkbox"/> no | # <input type="checkbox"/> staff to # <input type="checkbox"/> individuals | |
| Shore Fishing | <input type="checkbox"/> yes <input type="checkbox"/> no | # <input type="checkbox"/> staff to # <input type="checkbox"/> individuals | |
| Boating | <input type="checkbox"/> yes <input type="checkbox"/> no | # <input type="checkbox"/> staff to # <input type="checkbox"/> individuals | Life jacket mandatory for all |
| Swimming | <input type="checkbox"/> yes <input type="checkbox"/> no | # <input type="checkbox"/> staff to # <input type="checkbox"/> individuals | |
| Water Parks | <input type="checkbox"/> yes <input type="checkbox"/> no | # <input type="checkbox"/> staff to # <input type="checkbox"/> individuals | |
| Hot Tub Use | <input type="checkbox"/> yes <input type="checkbox"/> no | # <input type="checkbox"/> staff to # <input type="checkbox"/> individuals | Dr’s Order required for “Yes” |
| Able to access aquatic activities independent of staff supervision | <input type="checkbox"/> yes <input type="checkbox"/> no | If ‘yes’ is checked, the individual may only have an aquatic activity code of #5 | If ‘yes’ is checked, Water Safety Checklist has to be reviewed with the individual by staff <u>every year</u> between March 1st & May 1st |

Signature of Person Completing Form

Date

Relationship to Camper

Special Packing Instructions

Please be aware that it is warm during the day and cool at night.
Clothing for BOTH temperatures is needed at camp.

Laundry services are limited at camp. Therefore, campers should come with

The following is a list of clothing and other items which we recommend sending with the camper:

| | |
|---|---|
| Shirts & Sweatshirts | Toiletries (toothbrush, toothpaste, hair brush, shaving needs, shampoo, hair dryer, etc). |
| Shorts & Pants | Sanitary Products |
| Undergarments | Sun block |
| Pajamas | Bug Spray |
| Warm Bathrobe | |
| Comfortable Shoes | |
| Coat | |
| Laundry Bag | |
| Bath & Beach Towels | |
| Two Sets of Sheets, Pillow, Blankets (Big Comforter Recommended) | |

enough clothing to last throughout their ENTIRE stay at camp.

Special Notice Re: Medication:

It is vital that the following instructions be followed regarding medication. Failure to do so may result in the camper being sent home:

1. **All Medication** sent with the camper **must match written orders signed by a physician.** This must be listed on the Medication Order Sheet provided in this packet.
2. It is imperative that enough medication is sent to last the camper's entire one or two week stay.
3. Medication must be in the original drug store bottles with labels attached or in blister packs. **Pill boxes will not be accepted.**
4. Medications must be identical to those listed on the Medication Order Sheet you submit in advance. **If there are medication changes** which occur subsequent to your submission of the Medication Order Sheet, **an updated Written Order signed by a physician must accompany the medication.**

Special Notice Re: Bedding & Clothing-

1. Please be sure to pack enough clothes and bedding for the entire stay.
2. We cannot be responsible for items lost or stolen. Please mark items with the campers name or initials.
3. Please fill out the inventory list on the reverse side to help us keep track of the camper's belongings. Send this form to camp with the camper.

Camp Harkness Clothing Inventory

Camper Name: _____

| Item | Num | Description |
|-------------------|-----|-------------|
| Shirts | | |
| Shorts | | |
| Pants | | |
| Sweaters | | |
| Sweatshirts | | |
| Bathrobe | | |
| Shoes | | |
| Socks | | |
| Coat | | |
| Laundry Bag | | |
| Towels | | |
| Wash Cloths | | |
| Sheets | | |
| Pillow | | |
| Pillow Cases | | |
| Blankets | | |
| Sleeping Bag | | |
| Toothbrush | | |
| Toothpaste | | |
| Hair Brush | | |
| Shaving Needs | | |
| Shampoo | | |
| Hair Dryer | | |
| Sanitary Products | | |
| Underwear | | |
| Pajamas | | |

List Additional Items (Remember to bring additional sheets and blankets if incontinent):

Directions to Camp Harkness:

From Rte 395 S:

Take Exit 77 for Rte 85 south. Turn left at end of exit ramp onto Rte 85 South. Turn right onto Cross Rd. Follow Cross Rd to the end and turn left onto Rte. 1. Proceed east (toward Waterford/New London) on Rte 1 for 1.6 miles to a stop light. Take a right onto Avery Lane (Sylvia's Package Store will be on your right). Proceed 0.3 Miles to stop light. Proceed straight onto Rte 213 (Great Neck Rd). Proceed on Rte 213 down to the shoreline (past Harkness Memorial State Park on your right). Proceed to stop sign and turn right. Camp Harkness is the first right.

From Rte 95 N:

Take exit 75 onto Rte 1. Proceed east (toward Waterford/New London) on Rte 1 for 3.8 miles to a stop light. Take a right onto Avery Lane (Sylvia's Package Store will be on your right). Proceed 0.3 Miles to stop light. Proceed straight onto Rte 213 (Great Neck Rd). Proceed on Rte 213 down to the shoreline (past Harkness Memorial State Park on your right). Proceed to stop sign and turn right. Camp Harkness is the first right.

From Rte 95 S:

Take exit 81 (Cross Rd.) At the end of the exit ramp, turn left. Follow to traffic light. Turn left onto Cross Rd. Follow Cross Rd to the end and turn left onto Rte. 1. Proceed east (toward Waterford/New London) on Rte 1 for 1.6 miles to a stop light. Take a right onto Avery Lane (Sylvia's Package Store will be on your right). Proceed 0.3 Miles to stop light. Proceed straight onto Rte 213 (Great Neck Rd). Proceed on Rte 213 down to the shoreline (past Harkness Memorial State Park on your right). Proceed to stop sign and turn right. Camp Harkness is the first right.

Camp Harkness Map

