Clover Patch Camp 2026 Application

SESSION PREFERENCE

OVERNIGHT CAMP: Sunday – Friday
DAY CAMP Monday –Thursday 9:00 am – 5:00 pm (Option to Check-in Sunday)

Total number of sessions the camper would like to attend. _____ Number sessions in order of preference (1,2,…).

Session	Date	Age Range	Overnight	Day Camp
1	June 7-12	18+		
2	June 14-19	18+		
3	June 21-26	5-18		
4	June 28 – July 3	5-18		
5	July 5-10	18+		
6	July 12-17	18+		

PERSONAL INFORMATION

Camper Name: _____ Phone Number: _____

Preferred Name: _____ Gender: _____ Preferred Pronouns: _____

Address (*street/city/state/zip*): _____

County: _____ Age: _____ Date of Birth: _____

Camper Lives (check one): ☐ CFDS Residence ☐ Non-CFDS Residence ☐ Family Care Home ☐ At Home

Person Completing Application: _____ Relationship to Camper: _____

Address (☐ same as camper): _____

Phone Number (☐ same as camper): _____ Alternate Phone Number: _____

Email: _____ Fax Number: _____

Caregiver Name (if different from above): _____ Email: _____

Phone Number (if different from camper): _____ Alternate Phone Number: _____

Allergies (check all that apply)

☐ No Known Drug Allergies ☐ No Known Food Allergies ☐ Latex ☐ Seasonal ☐ Environmental

☐ Food: _____

☐ Medication: _____

Diagnosis (check all that apply)

- ☐ ADD/ADHD
- ☐ Alzheimer's / Dementia
- ☐ Arthritis
- ☐ Asperger's Syndrome
- ☐ Asthma
- ☐ Autism
- ☐ Behavior Disorder
- ☐ Cerebral Palsy
- ☐ Colostomy
- ☐ Developmental Delay
- ☐ Diabetes
  - ☐ Insulin dependent
  - ☐ Medication controlled
  - ☐ Diet controlled
- ☐ Down syndrome
- ☐ Hearing Impaired
  - ☐ Severe/Total Loss
  - ☐ Wears Hearing Aid(s)
- ☐ Intellectual Disability
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe/Profound
- ☐ Seizure Disorder
- ☐ Traumatic Brain Injury
- ☐ Vision Impaired
  - ☐ Severe/Total Loss
  - ☐ Wears Corrective Lenses
- ☐ Other (please specify): _____

MEDICAID

Does this camper currently receive Medicaid? ☐ YES ☐ NO

Care Coordinator: _____ Agency providing service: _____

Phone Number: _____ Email: _____

Medicaid #: _____ TABS ID#: _____

OPWDD Eligible?: ☐ YES ☐ NO Waiver Enrolled?: ☐ YES ☐ NO

GENERAL MEDICAL INFORMATION

Seizure Activity

Does the camper have a seizure disorder? ☐ YES ☐ NO

How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Controlled by medication Date of last seizure: _____

Describe type, duration, characteristics, known triggers, etc. _____

Does the camper use Vagus Nerve Stimulation (VNS)? ☐ YES ☐ NO

Skin Integrity

Does the camper have a history of skin breakdown? ☐ YES ☐ NO

Describe the history: _____

List preventive techniques: _____

Orthopedic Appliances and Equipment (check all that apply)

☐ Right Leg ☐ Left Leg ☐ Trunk ☐ Corset ☐ Right Hand ☐ Left Hand ☐ Helmet

☐ Other (please specify): _____

Schedule: _____

Mobility (check all that apply)

- ☐ Independent with all ambulation
- ☐ Walks with assistive device (cane, crutches, walker, etc.)
- ☐ Walks with direct staff support
- ☐ Uses a wheelchair
  - ☐ Manual ☐ Power
  - When? ☐ For long distances ☐ At all times
  - Can the camper self-propel? ☐ YES ☐ NO

Communication (check all that apply)

- ☐ Non-verbal
- ☐ Verbal and can be clearly understood by others
- ☐ Verbal but may be difficult to understand
- ☐ Uses communication board/device
- ☐ Uses sign language
- ☐ Gestures
- ☐ Other: _____

BEHAVIORS

Detail behaviors displayed at home, at school/program and in the community. In order to best prepare for and meet the needs of the camper, please provide accurate and detailed information.

Behavior	Daily	Weekly	Monthly	Yearly	Never	Explain/Details
Interacts with staff/peers	☐	☐	☐	☐	☐	
Destructive	☐	☐	☐	☐	☐	
Emotional outbreaks	☐	☐	☐	☐	☐	
Lying or stealing	☐	☐	☐	☐	☐	
Physically aggressive	☐	☐	☐	☐	☐	
PICA	☐	☐	☐	☐	☐	
Scratches, hits or grabs	☐	☐	☐	☐	☐	
Self-abuse	☐	☐	☐	☐	☐	
Self-stimulating behavior	☐	☐	☐	☐	☐	
Sensitive to touch	☐	☐	☐	☐	☐	
Temper tantrums	☐	☐	☐	☐	☐	
Uses inappropriate language	☐	☐	☐	☐	☐	
Wanders or runs away intentionally	☐	☐	☐	☐	☐	
Wanders unintentionally due to distractions	☐	☐	☐	☐	☐	

ACTIVITIES OF DAILY LIVING

Review all the activities of daily living listed below and provide details regarding required assistance.

ADL	Independent	Verbal Reminders	Physical Assistance	Total Support	Details
Bathing	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	
Oral Care	☐	☐	☐	☐	Wears dentures? ☐ Yes ☐ No Uses : ☐ Toothbrush ☐ Mouth Swabs (Toothettes) ☐ Mouth Wash
Toileting	☐	☐	☐	☐	
What is the word or method of toilet indication?					
Wears diapers (Attends)? ☐ Night ☐ Day ☐ Camper does not wear attends					
Females: Help with menstruation cycle? ☐ YES ☐ NO Help Required:					

Sleeping Pattern

Does the camper generally sleep well? ☐ YES ☐ NO Normal sleeping hours: _____

Does the camper require bed rails? ☐ YES ☐ NO Details: _____

Does the camper wet the bed? ☐ YES ☐ NO Details: _____

How often is the camper changed/tripped during the night? _____ Schedule: _____

Does the camper use the following? ☐ Urinal ☐ Bedpan ☐ Commode

Does the camper need bed checks? If yes, how often and why? _____

Please note. *We do not provide awake overnight staff. Two staff members sleep in each cabin nightly and are responsible for routine bathroom trips and assistance. We cannot accommodate campers who require consistent and frequent assistance throughout the night.*

ADDITIONAL INFORMATION

Is this the camper's first time attending Clover Patch? ☐ YES ☐ NO Years of attendance: _____

Has the camper ever attended a different camp? ☐ YES ☐ NO ☐ Day ☐ Overnight

Did the camper enjoy the experience(s) and adjust well? ☐ YES ☐ NO Details: _____

What were the camper's favorite things about camp? _____

What were the camper's least favorite things about camp? _____

Does the camper have any strong fears (e.g. darkness, water, thunder, bugs, animals, large crowds)? ☐ YES ☐ NO

Details: _____

What methods should be used to deal with these fears? _____

How does the camper react when upset, homesick or frustrated? What methods should be used to handle these behaviors? _____

Is there any further information that may be helpful in better understanding the camper and his/her needs at camp?

_____

_____

_____

To best meet the camper's needs, please send a copy of all applicable plans with the application.

- ☐ Life Plan
- ☐ Behavior or Risk Management Plan
- ☐ Individual Education Plan (IEP)
- ☐ Individual Plan of Protective Oversight and Safeguards (IPOP)

PAYMENT AGREEMENT

COST OF ATTENDANCE PER SESSION

Overnight $1,400 Day $650

PAYMENT DUE DATE

I understand that payment is due in full two weeks prior to my camper's first day of camp. I know I may contact Lori Hunt in the finance department to set up a payment plan or pay by credit card. Her phone number is (518) 437-5513. I can submit a check made out to Clover Patch Camp as well.

PLEASE INDICATE YOUR PAYMENT METHOD BELOW

1. **PRIVATE PAY**

☐ The below named camper is planning to attend Clover Patch Camp and will be paying privately. I will contact Lori Hunt in the finance department to make a payment or set up a payment plan. I understand that my balance must be paid in full two weeks prior to the below named camper's first day of camp.

2. **SELF-DIRECTED BUDGET**

☐ NO The below named camper has a self-directed budget but has not designated monies for camp.

☐ YES The below named camper does utilize a self-directed budget and has designated monies for camp as a part of their IDGS waiver.

FI Agency: _____

Name and Phone Number of contact at FI Agency: _____

3. **FSS SCHOLARSHIP**

This option is only available to those campers who live at home with family members in the capital district. Individuals that live in IRAs, family care homes, and foster care homes are ineligible. Individuals that utilize a self-directed budget are also ineligible. Scholarships are awarded on a sliding scale based on household size and income.

☐ I am a family member or advocate of the below named camper and I believe they are eligible for scholarship. Please send me a copy of the scholarship application.

☐ I am a family member or advocate of the below named camper and I have included a scholarship application.

WAIVER

All the information provided is accurate and complete to the best of my knowledge.

As the Parent/Guardian/Advocate of _____, I have read and understand the above.

Camper Name

_____ _____

Parent/Guardian/Advocate Signature *(please print out and sign)* **Date**

MARKETING AND MEDIA RELEASE FORM

Name of Camper: _____

I hereby grant to the Center for Disability Services ("CFDS") permission to film, video, and/or photograph (collectively, the "Media") me, or those for whom I am legally responsible.

I understand and acknowledge that CFDS may use the Media for advertisement, promotional, and/or marketing materials, in any and all form now known or later devised. I hereby grant to CFDS a perpetual, irrevocable, fully paid, royalty-free, universal and unconditional right to: (a) use, portray, publish, copy, distribute, display and generally use all or portions of the Media, including, without limitation, the name(s) of those depicted, fictional names (if any), voice, photographs, words, images, personality or other likeness (collectively, "Publicity Rights"); and, (b) copy, distribute, perform, display, and create derivative works from any copyright protected works or materials developed or created based in whole or in part on, or arising from or related to the Publicity Rights, for advertising, distribution, marketing, promotion, publicity, sales or any other lawful commercial purpose, in any form or manner, in whole or in part, in any electronic or non-electronic medium now known or later devised, as it relates to promoting CFDS. I also waive any right to inspect or approve the finished product.

In addition, I hereby release and hold harmless, CFDS, together with its respective employees, agents, affiliates, sponsors, or other representatives, from any and all claims, demands, or causes of action arising out of the use of the Media or Publicity Rights in accordance with the terms of this release form. I understand and agree that neither I, nor those for whom I am legally responsible, will be compensated in any way for the use of the Media or Publicity Rights.

Parent/Guardian/Advocate Signature: _____ Date: _____

Parent/Guardian/Advocate Name (printed): _____

If this release form is being signed on behalf of a minor, the signatory above acknowledges that he or she is over the age of 18 and is the parent and/or legal guardian of:

Minor's name (printed): _____ Age: _____

No Photos or Videos.

Parent/Guardian/Advocate Signature: _____ Date: _____

Parent/Guardian/Advocate Name (printed): _____

CONSENT

CONSENT TO TREAT

In the event of an emergency wherein any of the documented physicians are not available, I give my consent to provide treatment and to conduct any tests by appropriate Ellis Hospital staff on duty that are required to render necessary medical care.

CONSENT TO ATTEND AND PARTICIPATE

I give permission for the named camper to attend Clover Patch Camp and participate in all activities. I also agree not to send this individual to Camp if exposed to a contagious disease within 21 days of the date the applicant is to report to Camp, and I will notify the Camp Director immediately.

REFUND POLICY

I understand that if the named camper is sent home due to medical reasons determined by the camp health director, the camp fee will be prorated and refunded contingent upon the vacancy being filled. If the named camper does not wish to remain at camp, or if the camper is sent home due to behavioral issues, a refund will not be granted.

MEDICATION AUTHORIZATION (check one)

☐ NO The below named camper does not need to take any routine medication (prescription or over-the-counter) while at camp.

☐ YES The below named camper will need to take medication while at camp. I authorize administration of prescribed medications. I understand that it is my responsibility to ensure that the medications are labeled properly and that camp nursing has the corresponding med orders. The director of nursing reserves the right to decline the admission of any camper if their medications are not in order.

PERMISSION TO APPLY SUNSCREEN AND BUG SPRAY

I give the staff at Clover Patch Camp permission to apply bug spray and sunscreen that I have provided to the below named camper.

WAIVER

All the information provided is accurate and complete to the best of my knowledge.

As the Parent/Guardian/Advocate of _____, I have read and understand the above.
Camper Name

_____ _____

Parent/Guardian/Advocate Signature *(please print out and sign)* **Date**

EMERGENCY CONTACT INFORMATION

Camper Name: _____ Address: _____

Home Phone: _____ _____

Primary Contact

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

Alternate contacts in the event of an emergency, illness or injury

List individuals granted permission to pick up the camper at any time during the camper's session. Please inform the individual(s) prior to the camp session that they have been listed as a contact. Camp management will release the camper only to individuals listed below.

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

Name: _____ Relationship to Camper: _____

Phone Number: _____ Alternate Phone Number: _____

_____ _____

Parent/Guardian/Advocate Signature *(please print out and sign)* **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I have received a copy of the *Notice of Privacy Practices of the Center for Disability Services, Inc*. The Notice describes how my health/clinical information may be used or disclosed. I understand that I should read the Notice carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice from the Center's website https://cfdsny.org/about-us/privacy-notice or by contacting the Privacy Officer at 518-944-2129.

Camper Name: _____
(print)

Camper Entity Number: _____N/A_____

**Signature: _____ Date: _____

**As the representative of the above individual, I acknowledge receipt of the Notice on his/her behalf.

Signature: _____ Date: _____

For CFDS use only

Y	Yes – Individual received & acknowledgement was signed
R	Individual received and refused to sign
U	Individual received and unable to sign

SWIMMING PERMISSION

Does the below named camper have permission to swim at camp? ☐ YES ☐ NO

Does the camper enjoy swimming? ☐ YES ☐ NO

If the camper does not enjoy swimming, will he or she want to be at the pool during swim time? ☐ YES ☐ NO

Will the camper enjoy dipping his or her feet in the water? ☐ YES ☐ NO

What level swimmer is the camper? Check the appropriate box.

- ☐ **No Previous Swimming Experience** – camper has never swam before
- ☐ **One-on-One Support** – camper requires constant hands-on support at all times
- ☐ **Non-Swimmer** – will enter water with assistance
- ☐ **Beginner** – has swam before; limited swimming ability
- ☐ **Advanced Beginner** – can move through the water using a floatation device or mild physical assistance
- ☐ **Intermediate** – can support self in water, go under water
- ☐ **Advanced** – can independently swim

What type of personal flotation device best suits the camper?

- ☐ Aqua jogger
- ☐ Floatation Vest
- ☐ Floatation vest with additional head support
- ☐ Other: _____

Are there any swimming restrictions? ☐ YES ☐ NO Details: _____

_____

Please note.

1. An American Red Cross certified lifeguard is on duty at all times during swimming activities.
2. A 1:1 camper to staff ratio is maintained in the pool at all times regardless of swimming experience.
3. All swimmers are required to wear a personal flotation device in the pool regardless of swimming experience.
4. Socks or swim shoes are required for all swimmers.
5. All campers must have a signed swimming permission form to participate in swimming activities at camp.

As the Parent/Guardian/Advocate of _____, I have read and understand the above.

Camper Name

_____ _____

Parent/Guardian/Advocate Signature *(please print out and sign)* **Date**

TRANSFER/POSITIONING/MOBILITY

☐ **A Current Mobility Fact Sheet will be submitted (IRA/Program) OR** ☐ **A Camp Mobility Sheet will be completed below**

Camper Name: _____ Height: _____ Weight: _____

Check one.

☐ The individual is independent with all ambulation and mobility.

☐ The individual requires assistance with transfers and/or mobility.

TRANSFERS – LEVEL OF ASSISTANCE

☐ Mechanical lift (with sling – must be used with clients weighing over 150 lbs.)

☐ Two-person lift (unable to bear weight or assist with transfer; client must weigh less than 150 lbs.)

☐ One-person lift (client must be under 42 in. and less than 50 lbs.)

☐ Stand-pivot transfer

☐ Sliding board transfer

☐ Independent

☐ Alternative transfer (specify): _____

Comments: _____

WHEELCHAIR MOBILITY – LEVEL OF ASSISTANCE

Type of wheelchair used (check one): ☐ Manual Wheelchair ☐ Power Wheelchair

Endurance (distance/time): _____ Method of propulsion: ☐ Self ☐ Caregiver dependent

Indicate level of supervision for each of the following (use KEY below).

_____ Propels forward _____ Level Surfaces _____ Scoots forward/back in w/c

_____ Propels backward _____ Uneven Surfaces _____ Weight-shift in w/c

_____ Maneuvers around objects _____ Negotiates ramps

Comments: _____

_____

AMBULATION – LEVEL OF ASSISTANCE

Type of Assistive/Protective Device: _____ Endurance (distance/time): _____

Indicate level of supervision for each of the following (use KEY below).

_____ Level surfaces _____ Uneven surfaces _____ Stairs/curbs _____ Inclines

Comments: _____

_____

KEY I = Independent S = Supervision D = Dependant

POSITIONING

Check all that apply.

The individual is <u>independent</u> with:

☐ In-wheelchair positioning ☐ Out-of-wheelchair positioning

The individual is <u>dependent</u> with:

☐ In-wheelchair positioning ☐ Out-of-wheelchair positioning

DAILY POSITIONING/REPOSITIONING

What assistance does this individual require for positioning/repositioning during the day? _____

_____

_____

_____

_____

Frequency of out-of-chair repositioning: _____ Length of time: _____

Equipment: ☐ Floor mat ☐ Bed ☐ Wedge ☐ Pillows

Level of supervision necessary while in this position: _____

DINING POSITIONING

☐ Standard chair

☐ With arms ☐ Without arms

☐ Wheelchair (specifications): _____

☐ Special chair (specifications): _____

SLEEPING POSITIONING

In what position does the camper prefer to sleep during the night? _____

_____

_____

_____

What assistance does this individual require for positioning during the night? _____

_____

_____

_____

_____

Equipment: ☐ Side rails ☐ Wedge ☐ Pillows

Level of supervision necessary while in this position: _____

DINING FACTS

☐ **A Current Dining Fact Sheet will be submitted (IRA/Program) OR** ☐ **The Dining Facts Sheet will be completed below**

Camper Name: _____ Age: _____ Date of Birth: _____

Food Allergies: _____

Special Diet/Nutrition: _____

Medical Precautions: _____

LEVEL OF DINING ASSISTANCE REQUIRED

☐ **NPO**	Consumes no food or liquid by mouth. Tube-fed only
☐ **High Need**	Requires ongoing assessment/monitoring due to health concerns and swallowing disorder or requires specific training of techniques
☐ **Consistent**	Levels of assistance range from providing minimal prompts to needing to directly dine.
☐ **Supervised**	May require assistance with set-up, cut-up and/or clean-up.
☐ **Independent**	Requires no supervision during dining/training protocol

FOOD SET-UP – CONSISTENCY

☐ **NPO**	Consumes no food or liquid by mouth. Tube-fed only
☐ **Puree**	Food is prepared using a food processor until smooth, achieving an applesauce-like or pudding consistency.
☐ **Ground**	Food is prepared using a food processor until moist, cohesive and no larger than a grain of rice.
☐ **¼" Pieces Cut to Size**	Food is cut with a knife or chopped in a food processor into ¼-inch pieces.
☐ **½" Pieces Cut to Size**	Food is cut with a knife or chopped in a food processor into ½-inch pieces.
☐ **1" Pieces Cut to Size**	Food is served as prepared and cut by staff into 1-inch pieces.
☐ **Whole**	Food is served as it is normally prepared; no changes are needed in preparation or consistency.

FOOD SET-UP – PORTION/ADAPTIVE EQUIPMENT

Portion Size:	☐ ¼ teaspoon ☐ ½ teaspoon ☐ ¾ teaspoon ☐ 1 spoonful
Utensil:	☐ Regular ☐ Teflon-coated spoon ☐ Plastic spoon ☐ Maroon spoon
	☐ Spoon/fork with built-up handle ☐ Curved spoon **[** ☐ right ☐ left **]** ☐ Other: _____
Dish:	☐ Regular ☐ High sided dish ☐ Scoop dish ☐ Inner lip plate ☐ Dycem

BEVERAGE SET-UP – CONSISTENCY

☐ **Thin Liquid**	Liquids are served without change.
☐ **Nectar Thick Liquid**	The thickened liquid flows from the spoon in one steady stream. The consistency of the heavy syrup found in canned fruit, or maple syrup.
☐ **Honey Thick Liquid**	The thickened liquid flows slowly from the spoon but still pours. The consistency of table honey in squeeze bottle containers.
☐ **Pudding Thick Liquid**	The thickened liquid does not pour from the spoon. The spoon stands up in the product and requires a spoon for eating.

BEVERAGE SET-UP – PORTION/ADAPTIVE EQUIPMENT

Portion Size: ☐ Single Sip ☐ Consecutive Sips ☐ Spoon Fed ☐ Other: _____

Cup: ☐ Cut-out cup ☐ Sippy cup ☐ Cup with built-in straw ☐ Handled mug
☐ Regular **[** ☐ with disposable straw ☐ no straw **]** Other: _____

POSITIONING NEEDS (Note the positioning for the individual and the dining assistant.)

☐ Individual sits in a regular chair at the table

☐ Individual sits in a wheelchair at the table (specifications): _____

☐ Dining assistant positioning: _____

☐ Additional details: _____

INDIVIDUAL DINING PLAN (i.e. self-feeding, drinking, chewing/swallowing, placement of food, rate, prompts, dry spooning, routine after meal, etc.)

HEALTH ASSESSMENT

Camper Name: _____ Date of Birth: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Primary Physician: _____ Phone Number: _____

Address: _____

Surgeon (if applicable): _____ Phone Number: _____

Address: _____

Specialist (if applicable) _____ Phone Number: _____

Address: _____

ALLERGIES (check all that apply)

☐ No Known Drug Allergies ☐ No Known Food Allergies ☐ Latex ☐ Seasonal ☐ Environmental

☐ Food: _____

☐ Medication: _____

SEIZURE ACTIVITY

Does the camper have a seizure disorder? ☐ YES ☐ NO

How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Controlled by medication Date of last seizure: _____

Describe type, duration, characteristics, known triggers, etc. _____

Does the camper use Vagus Nerve Stimulation (VNS)? ☐ YES ☐ NO

SKIN INTEGRITY

Does the camper have a history of skin breakdown? ☐ YES ☐ NO

Describe the history: _____

IMMUNIZATIONS (Give all dates of inoculation ***or*** attach a copy of the vaccination record.)

Hepatitis B	Attach a lab report that includes HepBSag, HepBSAb, HepBCoreAB ***OR*** Documentation of vaccination. Dates of inoculation:
Tetanus	Date of inoculation:
Children (5-21 years) must also show documentation of the following.	
Measles/Mumps/Rubella (MMR)	Dates:
Diphtheria (DPT)	Dates:
Haemophilus Influenza Type B	Dates:
Poliomyelitis	Dates:
Varicella (Chicken Pox)	Dates:

PHYSICAL EXAM

Camper Name: _____ Date of Birth: _____

This section must be completed by a licensed medical professional. The exam must be within 12 months of attendance at camp. You may either submit the information on this form or attach a similar form required for school, day program, or other extra-curricular activities. Attach a copy of the Progress Notes, if available.

Due to health and safety considerations, we are unable to admit campers who have medically prescribed fluid restrictions. Our facilities experience high heat and humidity during upstate New York summers, making it unsafe to reliably maintain limited fluid intake.

SYSTEMS REVIEW

Height: _____ Weight: _____ Pulse: _____ BP: _____ Respiration: _____

✓ **IF WITHIN NORMAL LIMITS.**

WNL	System	Notes
☐	General Appearance	
☐	Abdomen (hernia)	
☐	Breasts	
☐	Chest-lungs	
☐	Ears/Hearing	
☐	Extremities	
☐	Eyes/Vision	
☐	Heart	
☐	Mouth	
☐	Neck/Thyroid	
☐	Neurological	
☐	Pelvic/Genitalia/Rectal	
☐	Skin	

MEDICAL HISTORY

Chronic Health Problems	
Recent Illnesses	
Operations/Injuries	

RECOMMENDATIONS / RESTRICTIONS WHILE AT CAMP

I have examined this individual and have reviewed his/her medical history. It is my opinion that he/she is physically able to participate in camp activities at Clover Patch Camp, except as noted above.

Physician Signature **Physician's Name (print)** **Date**

STANDING EMERGENCY ORDERS

Camper Name: _____ Date of Birth: _____

Medication Allergies: _____

Medications may be used for 48 hours then consult MD for further orders. Medications to be given PO or G-tube unless otherwise indicated. To be reviewed annually by MD.

✓ **WHICH ORDERS APPLY**

☐ **Ibuprofen** – 200 mg tab give one PO/PT Q6H PRN for temp>100, headache, pain. MDD 4 doses.

☐ **Acetaminophen** – 325 mg tab give two PO/PT Q4H PRN for temp>100, headache, pain. MDD 5 doses.

☐ **Acetaminophen Rectal Suppository** – 650 mg give one PR Q4H PRN for temp>100, headache, pain. MDD 5 doses.

☐ **Robitussin Cough and Chest Congestion DM** – 20 ml give PO/PT Q4H PRN for cough with cold symptoms. MDD 4 doses.

☐ **Mylanta** – 20 ml give PO/PT Q4H PRN for complaints of gastric upset. MDD 6 doses.

☐ **A+D Ointment** – Apply thin layer to reddened areas on a perianal area/buttocks PRN and after each diaper change. Notify guardian/parent after three days for further orders.

☐ **Neosporin, Bacitracin or Triple Antibiotic Ointment** – Apply thin layer to minor cuts or skin abrasions BID PRN.

☐ **Sunscreen SPF 30** – PABA free to all exposed skin surfaces prior to sun exposure.

☐ **Bug spray** – OFF Deep Woods insect repellent 25% DEET. Cover exposed skin and/or clothing as needed.

☐ **Benadryl Elixir** – 12.5 mg per 5 ml give 10 mg PO/PT TID PRN for rash or persistent itch. MDD 3 doses.

☐ **Benadryl Tabs** – 25 mg tab give one tab TID PO/PT PRN for rash or persistent itch. MDD 3 doses.

☐ **Caladryl/Benadryl Lotion** – Apply sparingly to affected area of bug bite, rash, or minor skin irritation TID PRN.

Clover Patch Camp Bowel Protocol:

☐ **Milk of Magnesia** – Give 30 ml PO/PT at 1pm on day 3 of no BM PRN for constipation.

☐ **Ducolax Suppository** – 10 mg give PR PRN at 8pm on day 4 of no BM.

☐ **Fleet Enema** – Administer one enema PR PRN at 1pm on day 4 of no BM.

☐ **Kaopectate** – 262 mg per 15 ml suspension. Give 30 cc PO/PT after each loose bowel movement not to exceed 4 g in 24h.

☐ **Please see attached signed and dated individualized bowel protocol**

☐ **NO STANDING ORDERS ARE APPLICABLE**

Authorization: I do hereby grant permission for the camp healthcare providers to follow the above medication orders.

_____	_____	_____
Physician Signature	**Physician Name (print)**	**Date**

MEDICATION RECORD

Camper Name: _____ Date of Birth: _____

- ⇨ **A doctor's order is required for all prescription medications, over-the-counter medications, and natural remedies, including topical treatments.**
- ⇨ **Any medication that has been added or discontinued prior to arrival at camp must be accompanied by a written doctor's order or a copy of the prescription.**

☐ This individual will not take any routine medications while attending camp.

☐ This individual will take routine medications while attending camp.

MEDICATION ADMINISTRATION

How does the camper take medications? ☐ Orally ☐ G/J-tube

How does the camper take pills? ☐ Crushed ☐ Swallows whole

With what does the camper mix the medication?

☐ Applesauce ☐ Vanilla Pudding ☐ Chocolate Pudding ☐ Other: _____ ☐ Beverage: _____

Does the camper require thickened liquids? ☐ NO ☐ YES Consistency: ☐ Nectar ☐ Honey ☐ Pudding

Medication Name / Strength	Amount	Route	Frequency	Hour	Purpose	Prescribing Physician

Authorization: I do hereby grant permission for the camp healthcare providers to follow the above medication orders.

_____ _____ _____

Physician Signature **Physician Name (print)** **Date**

Camper Name: _____ Date of Birth: _____

Medication Name / Strength	Amount	Route	Frequency	Hour	Purpose	Prescribing Physician

Authorization: I do hereby grant permission for the camp healthcare providers to follow the above medication orders.

Physician Signature **Physician Name (print)** **Date**