

ALLERGIES

No Known Allergies This camper is allergic to the following (list all known).
Please describe below what the camper is allergic to and the reaction seen.

Medications (list)

Foods (list)

Environmental or Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

DIET, NUTRITION

This camper eats a regular diet. This camper eats a regular vegetarian diet.
 This camper has special food needs. **Please describe these needs 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 these needs below.**

GENERAL HEALTH QUESTIONS

(explain "yes" answers below.)

Has/does the participant:

	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma/wheezing/shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months.	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking/falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had dizziness or fainting?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bedwetting?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	29. Traveled outside the US in the past 9 months?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?...	<input type="checkbox"/>	<input type="checkbox"/>	30. Had a tetanus booster in the past 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>

Please explain "Yes" answers from above, noting the number of the questions. For travel outside the US, please name countries visited and dates of travel.

Please identify any medications taken during the school year that participant does/may not take during the summer.

MENTAL, EMOTIONAL & SOCIAL HEALTH Check "Yes" or "No" for each statement.

Has the participant:

Yes No

- 1. Ever been treated for attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)? 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 from above, noting the number of the questions. The camp may contact you for additional information.

IMMUNIZATION HISTORY Provide the month/year for each immunization. Starred (*) immunizations must be current. A copy of the immunization record from the health care provider is also acceptable. Copy attached? Yes No

Which of the following has the participant had? Measles Chicken Pox German measles Mumps
 Hepatitis A Hepatitis B Hepatitis C Tuberculosis (TB) test Date: _____ Negative Positive

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
Diphtheria, 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) <input type="checkbox"/> Had/Date _____						
Meningococcal meningitis (MCV4)						

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 Parent/Guardian: _____ Relationship to Camper: _____ Date: _____

MENINGOCOCCAL VACCINATION RESPONSE FORM New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete the following information. Check one box and sign below.

My child has had meningococcal meningitis immunization within the past 10 years. Date received: _____

[Note: If your child received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.]

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Signature of Parent/Guardian: _____ Relationship to Camper: _____ Date: _____

HEALTH CARE PROVIDERS

Name of primary care physician _____ Phone (____) _____

Name of family dentist _____ Phone (____) _____

Name of family orthodontist _____ Phone (____) _____

CONFIDENTIAL CAMPER INFORMATION FORM The staff of Camp Onyahsa cares about your camper and the following information (provided only to Administrative and Cabin Staff) will help us to better serve her or him and further help us to ensure an optimal camping experience.

Camper's Name: _____ Age: _____ Session(s): _____

1. Does your child have any special needs or circumstances that require extra attention? (i.e. physical or mental challenges, learning disabilities, ADD/ADHD, family situations, major life transitions within the past year, etc.)

2. Has your child received in-school or out-of-school suspension, or has he/she been assigned by the school or other authorities to a restrictive placement for behavioral/disciplinary reasons, been involved in a legal infraction or seen a professional to address mental or emotional health concerns within the past 12 months? **If yes to any of the above, please contact the Camp Office.** A letter from a school official or medical professional attesting to the appropriateness of the camp program to the child's needs will be required prior to acceptance of the camper's application.

3. Are there any behaviors the staff should be aware of; (bedwetting, sleepwalking, shyness, aggressiveness, eating habits, etc.)?

4. The Camp Staff will exercise a reasonable amount of discipline to enforce Camp rules. What works best should this be necessary with your child?

5. Many campers will experience homesickness early in their session. Short of calling home as our first response, what do you suggest?

6. Has your child ever been treated for emotional or behavioral difficulties or an eating disorder?

7. Are there any recent significant life events we should be aware of; (foster situation, custody, major transitions, history of abuse, divorce, births, deaths, etc.)?

8. Who sent this camper to Onyahsa?

9. What school does your child attend? What grade? Have there been any recent problems in this environment?

10. Are there any restrictions to be placed on your child's activities?

11. What are your camper's interests and dislikes?

12. What does your camper want to get out of the Camp experience (i.e. goals)?

13. Is there anything else we should know to help ensure a wonderful camp experience for your camper?

WHAT HAVE WE FORGOTTEN TO ASK? Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware. Attach additional information if needed.

OFFICE USE: Camper Name _____ Res Day Session(s) _____ Cabin _____ Health Check _____

CAMPER RELEASE PERMISSION FORM Communicate this information to the counselor upon check-in. Must sign in and out with the camper's Unit Leader at registration and departure and be prepared to show identification prior to leaving with the camper.

Who may pick up your child?

Name _____ Relationship to Camper _____

Name _____ Relationship to Camper _____

Who may NOT pick up your child? Please attach appropriate court documents.

Name _____ Relationship to Camper _____

Name _____ Relationship to Camper _____

My child has permission to stay the weekend with the family named below.

Name _____ Relationship to Camper _____

PHOTO AND VIDEO/AUDIO RECORDING RELEASE

For my participation in activities to be conducted by Jamestown Area Family YMCA, I hereby give my permission and consent, now and for all time, to Jamestown Area Family YMCA, the National Council of Young Men's Christian Associations of the United States of America (YMCA of the USA) and third parties collaborating with Jamestown Area Family YMCA and/or YMCA of the USA to make, reproduce, edit, broadcast or rebroadcast any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience at Jamestown Area Family YMCA, for publication, display, sale or exhibition thereof in promotions, advertising and legitimate business uses without any compensation to, and/or claim, by me. I may, or may not be, identified in such reproductions; however, I shall not be stated by name to have endorsed any particular commercial products or commercial services.

I further agree to the following:

- Any video film, footage, sound track recordings, and photo reproductions of me and/or my narrative account of my experience at Jamestown Area Family YMCA, I authorize, according to this Release, shall belong to Jamestown Area Family YMCA, YMCA of the USA and third parties collaborating with Jamestown Area Family YMCA and/or YMCA of the USA. Therefore, they will have full right of disposition of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience Jamestown Area Family YMCA;
- Any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience Jamestown Area Family YMCA will not be subject to any obligation of confidentiality and may be shared with and used by Jamestown Area Family YMCA, YMCA of the USA and third parties collaborating with Jamestown Area Family YMCA and/or YMCA of the USA;
- Jamestown Area Family YMCA, YMCA of the USA and third parties collaborating with Jamestown Area Family YMCA and/or YMCA of the USA shall not be liable for any use or disclosure to a third party of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience at Jamestown Area Family YMCA; and
- Jamestown Area Family YMCA, YMCA of the USA and third parties collaborating with Jamestown Area Family YMCA and/or YMCA of the USA shall exclusively own all known or later existing rights to worldwide and shall be entitled to the unrestricted use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience at Jamestown Area Family YMCA for any purpose without compensation to me.

I agree that my consent and this release are irrevocable. I hereby release and discharge Jamestown Area Family YMCA, YMCA of the USA and third parties collaborating with Jamestown Area Family YMCA and/or YMCA of the USA from any and all claims in connection with the uses and reproductions of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience Jamestown Area Family YMCA as described herein.

I am the Mother/Father/Legal Guardian of _____ (child's name). For the consideration contained herein, I hereby consent to the foregoing on behalf of my minor child.

Signature of Custodial Parent/Legal Guardian/Adult Camper/Staff: _____

Printed Name: _____ **Date:** _____

CODE OF CONDUCT Must be signed at the bottom of this page by **camper and parent/legal guardian** prior to camp attendance.

1. The YMCA is strictly a drug, alcohol, weapon (including pocket knives), tobacco, harassment-free and abuse-free association.

2. The following areas are off limits unless supervised by Camp Onyahsa Senior Staff and/or Lifeguard Certified Camp Staff and/or properly trained Staff:

- a. The **Lake**; no swimming, boating, waterfront use, or dock-based fishing. The **Creek**; no participant will approach or enter the Creek at any time, go beyond the stockade/chain linked fence at anytime or cross the bridge without Senior Staff supervision and approval.
- b. The **Challenge Course**, and **Archery Range**; use is available only under the supervision of trained staff.
- c. The **Kitchen, Pantry, Camp Store, Camp offices, Maintenance sites, Health Office** and other functional/utilities areas.
- d. **Camp Fire areas** and the **Dining Hall fireplace**.
- e. **Cabins** or other living areas to which the participant has not been assigned. This includes staff sections of cabins and twin lodging areas of double cabins. Entrance to cabin areas of the opposite gender is prohibited.
- f. The **Onyahsa Nature Preserve** (satellite site), and the **highway** (Route 430/East Lake Road).
- g. The use of **Camp Equipment** is permissible only with staff approval.

3. The Lakefront, Creek banks, bridge, Point, water-filled ditches, driveway, parking areas, areas of on-campus vehicle use, fire circles, fireplace, woods, tree climbing, large wooded satellite site, slippery surfaces (including wet floors, bathrooms, decks, stairways, icy surfaces, lake ice, and saturated ground areas) are potentially hazardous, and caution is advised at all times.

4. Please respect the following rules to remain fully enrolled in the Camp Program:

- a. **Per Health Department regulations, campers must remain under the supervision of adult staff at all times.**
- b. No visitors are allowed in participant living areas except during check-in or departure times.
- c. All visitors must register at the Camp Office (mid-session) or at the registration desk (during Camper check-in).
- d. Departing campers must check-out with the director on duty, and check-in again upon their return during mid-session departures or with Village Directors during normal departure times. No participant may leave other wise.
- e. No camper should be alone, in private, with another Camp Participant (campers or staff). This policy includes shower, bathroom, cabin areas, and other secluded areas. Campers should remain in common, visible areas unless two other persons are present.
- f. Inappropriate touching, remarks, photography, or other behavior should be reported immediately to the Camp administration. Vulgarity, derogatory remarks, and harassment will not be tolerated.
- g. Respect the property and privacy of other participants. Do not touch others nor use their belongings without their permission. Theft will result in expulsion from the program.
- h. Females will not share tampons or other feminine products. If such items are needed, consult the Camp Nurse.
- i. Camp is a place for special friendships, but not one for romantic relationships involving campers who are minors. Campers involved in such relationships will be warned, and if the behavior continues, parents will be notified.
- j. Campers may not push the wheelchairs of participants with handicapping conditions.
- k. Cellular phone use by campers is prohibited except during designated times. Any phones in Camp must be secured by the group's adult leader.
- l. Please use trash cans for all litter. Medical waste containers are available for special items.
- m. No fires may be lit in Camp except by Senior Staff members as part of a scheduled and approved program. Campers are not to have matches or lighters on site.
- n. No driving on the Camp lawn. Overflow parking is permissible on the upper field. Drivers must use caution at all times. The Camp speed limit is 10 mph.
- o. No glass or bottles on the waterfront.
- p. Properly sized lifejackets must be worn at all times by youth and adult Camp boat users.
- q. If on a trip away from Camp, campers may not interact with the public or use public restrooms without staff permission.
- r. This list is not exhaustive. Participants will be expected to act with responsibility and common sense appropriate to their level of cognitive development during their stay at YMCA Camp Onyahsa.

5. A tour of the Camp will be held early in each session for all campers, at which time these policies may be described in more detail. Participants may also see the Administrative Staff at any time or may contact the Camp Director, Jon O'Brian, at 716-664-2802 ext. 223 (pre-season), or 716-753-5244 (in-season), for clarification.

I have read and reviewed this Code of Conduct with my child. We understand and fully agree to abide by it. We agree to release the Confidential Camper Information on page 4 to the appropriate Camp Staff.

Signature of Camp Participant _____ **Date** _____

Signature of Parent _____ **Date** _____

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL Physicians/health care providers, please review pages 2 and 3 of camper's Health History, completed by the parent/guardian. Complete this page (7) and page 8. Attach additional information if needed. **Your signature is required at the bottom of this page.**

Camper's Name: _____ Birth Date _____ Age: _____ Male Female

Today's date _____ Physical Exam done today? Yes No (If "No", date of last physical: _____/_____/_____)*

* American Camp Association (ACA) accreditation standards specify physical exam within last 12 months.

Weight _____ lbs Height _____ ft _____ in Blood Pressure _____/_____/_____ Pulse _____ BMI _____

Corrected Vision _____ Hearing _____

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

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

Allergies: No known allergies. To foods: (list) To medications: (list) To the environment (insect stings, hay fever): (list) Other allergies (list) **Describe previous reactions to any allergies:**

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

If you answered "Yes", what do you recommend? (describe below)

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

Additional Orders: (peak flows, blood draws/lab work, dressing changes, cast care, feedings via GT, etc.) (describe below)

I have reviewed the Camper Health History and have discussed the camp program with the camper's parent(s)/guardian(s). Based on my knowledge of the camper's health and behavioral characteristics, in my position as his/her primary care physician, I deem that the camper is:

is able to participate in an active camp program is not able to participate in an active camp program

Physician's Signature _____ Title _____

Physician's Name Printed _____ License # _____

Office Address _____
Street Address City State Zip

Phone Number _____ Fax Number _____ Date _____

I also give my permission for the medications indicated on page 8 to be given to my child if needed.

Signature of Parent/Guardian _____ Date _____

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL Physicians/health care providers, please complete this page.

PRESCRIBED MEDICATIONS BEING TAKEN This camper will not take any daily medications while attending camp.
 This camper will take the following prescribed medication(s) while at camp.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please list **ALL** medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Name of Prescription Drug/ Medication	Date Started	Reason for Taking	When it is given	Amt or Dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:_____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:_____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:_____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time:_____		

PHYSICIANS INDIVIDUAL ORDERS FOR OVER THE COUNTER MEDICATIONS This information is required for all resident camps by the State of New York. The following medications or their generic equivalents may be available in the Health Center and will be administered at the discretion of the Camp Health Director, if prior written approval is hereby indicated by the participants primary health care provider.

Over the Counter Medication	Needed/Used to treat	Physician Permission	Amt or Dose	How it is given
Acetaminophen (Tylenol)	Fever, headache, pain reliever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ibuprofen (Advil, Motrin)	Fever, headache, pain reliever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Phenylephrine/psuedoephedrine decongestant (Sudafed & PE)	Nasal congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diphenhydramine antihistamine/ allergy medicine (Benadryl)	Allergies, allergic reactions, nasal congestion, insect bites	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Guaifenesin/dextromethorphan cough syrup (Robitussin & DM)	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sore throat spray (Chloraseptic), throat lozenges	Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Lice shampoo or cream (Nix)	Lice, nits	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Antibiotic cream/ointment	Wounds, cuts, abrasions	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hydrocortisone cream	Insect bites, plant reactions	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Laxative (Milk of Magnesia)	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Imodium AD, Kaopectate	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bismuth subsalicylate (Pepto Bismol), Tums, Maalox	Upset stomach	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Calamine lotion (Caladryl)	Insect bites, plant reactions	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Rubbing alcohol, peroxide	Wounds, cuts, abrasions	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Burn jel, Aloe, Lanacane	Burns, sunburn	<input type="checkbox"/> Yes <input type="checkbox"/> No		