Safety Patrol Leadership Camp

<u>Clothing and Equipment Packing List</u>

Note: You will be limited to one suitcase and one bedroll. ***(Make sure name is on suitcase and bedroll)***

Bedroll: Sleeping bag or one / two blankets and sheets. Pillow and pillow case if you want one.

Clothing: We suggest that you bring clothing that you would wear for after-school activities. ***(Clothing should be marked)***

Packed = ✓

- _____ One pair of pajamas
- _____ Two pair of shoes (tennis shoes)
- _____ Daily change of socks and underclothes
- _____ Heavy and light shirts
- _____ Jacket and/or light sweater
- _____ Handkerchiefs / small pack of tissues
- _____ Raincoat
- _____ Jeans or slacks (2 or 3 pair)
- _____ Shorts (weather permitting)
- _____ Swim suits

Toiletries:

- _____ Toothpaste
- _____ Toothbrush
- _____ Soap
- _____ Bath towels (2)
- _____ Washcloths (2)
- _____ Comb / brush

General Equipment:

- _____ Flashlight (batteries?)
- _____ Pencil's
- _____ Notebook (not loose-leaf paper)

DO NOT BRING:

Radios	Comic books	Food	Chewing gum	Money
Cards	Knives	Axes	Firearms	Cell Phones

For further information, call the Safety Council of Northwest Ohio at (419) 662-7777

SAFETY PATROL LEADERSHIP CAMP

MEDICATION AUTHORIZATION

Please put this paper in a Ziploc bag with the medications in their proper container, and bring to check-in. Can include over the counter as long as they are in original unopened container

Student's Name: ____

Medicine Name	Milligrams	Dose (tablespoon, tablet, etc.)	Per day / hours

Parent / Guardian Name *(Print)*: ____________________________________

Parent / Guardian Signature: ______________________________________

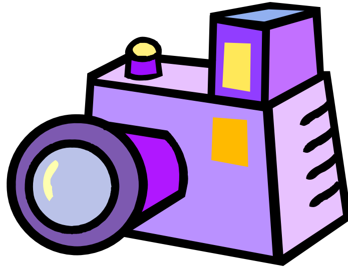
Date: _________________ Contact Phone #'s: ____________________

Cell _______________________________

- BELOW THIS LINE TO BE COMPLETED BY STAFF -

Lodge: ______________________ Cabin #: _______________________

RETURN TO SAFETY COUNCIL ON WEDNESDAY, SEPTEMBER 9TH



Safety Council of Northwest Ohio

Photo Consent and Release Form

From time to time photographs may be taken of youth and adults engaging in Camp programs and activities (example: picnics, games, classes). Safety Council of Northwest Ohio requests the right to use these photos for our website or to showcase our activities in the local newspaper.

By signing this form, I confirm that I understand and agree to the above request and conditions. I sign this form freely and without inducement.

My Contact Information:

Student Name (print):____

Address:____

____

Phone Number:_________________________Email Address:_____________________________

Student Signature:_____________________________________Date:_____________

Parent/Guardian's Signature:_____________________________Date:______________

RETURN TO SAFETY COUNCIL ON WEDNESDAY, SEPTEMBER 9TH

Safety Council of Northwest Ohio
Safety Patrol Leadership Camp

Parent/Guardian Permission, Acknowledgment and Release

The child named below has the permission of the undersigned parent(s)/guardian to participate in the Safety Patrol Leadership Camp. I/we hereby give permission to the Safety Council of Northwest Ohio to secure emergency medical care for the child named below while at camp or while traveling to or from camp. I/we understand that health insurance coverage is the responsibility of the parent/guardian, and that the Safety Council of Northwest Ohio is not responsible for payment of any medical expenses incurred during participation at camp or traveling to or from camp.

In consideration for the child named below being allowed to participate in this program, I/we agree to assume the risks of participation in the program, and further agree to release and hold harmless the Safety Council of Northwest Ohio, its officers, employees, instructors, cabin leaders, members and representatives from any and all claims, suits, losses, or related causes of action arising out of participation in this program by the child named below.

Student's Printed Name:______________________________

I/We have read and understand and agree to the foregoing, and my/our child identified above has my/our permission to participate in the Safety Patrol Leadership Camp.

Parent/Guardian's Signature: ____________________________ Date: _________________

Parent/Guardian's Signature: ____________________________ Date: _________________

Return to Safety Council on Wednesday, September 9th

Insurance Information

Please include a copy of your insurance card.

YMCA Storer Camps' does NOT carry health/accident insurance for campers, schools, and conference camping participants.

Primary Policy Holder	Insurance Company	Policy Number	Relationship to Child
Secondary Insurance Holder	Insurance Company	Policy Number	Relationship to Child
Physician's Name	Physician's Phone Number	Date of Last Visit	

Health History

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current.

Immunization	Date: Month(s) & Year(s)	Immunization	Date: Month(s) & Year(s
Tetanus Booster ★	Within 10 years:	Polio ★	
Varicella (Chicken Pox)		MMR (Measles, Mumps, Rubella) ★	
Meningitis		Pneumoccocal	
Pertussis Booster (Whooping Cough)		DPT (Diphtheria, Tetanus, Pertussis) ★	
Hepatitis B		Hepatitis A	
Influenza			

Allergies: Check those that apply to your student.

❑ This student has no known allergies.

❑ This student is allergic to this food(s). ___________________

____

Causes anaphylaxis? ☐ Yes★ ☐ No

Describe the reaction to this food and what is done to manage it: _____________________________________

____

❑ This student is allergic to this medication: ______________

Causes anaphylaxis? ☐ Yes★ ☐ No

Describe the reaction and how it is managed: ___________

____

❑ This student is allergic to the following: ________________

Causes anaphylaxis? ☐ Yes★ ☐ No

Describe the reaction and what is done to manage it: ____

____

Nutrition:

Our kitchen prepares well-balanced meals. We can work with some medically prescribed diets but do not cater to individual food preferences.

❑ This student eats a regular diet.

❑ This student is the following type of vegetarian.

- ☐ Semi-vegetarian (no pork or beef)
- ☐ Pesco (no pork, beef or chicken)
- ☐ Lacto-ovo (no pork, beef, chicken, seafood or fish)
- ☐ Vegan (no meats, seafood, eggs or dairy)

❑ This student does not eat pork because of faith reasons.

❑ This student is lactose-intolerant. Note: our expectation is that the student self-manages using products such as Lactaid.

Chronic Health Concerns: Check those that pertain to your student and describe how it is handled at home.

❑ This student has no chronic health concerns and is capable of full participation in the OEE program.

❑ This student has the following chronic health concern(s):

☐ Asthma ★ ☐ Bedwetting ☐ Seizure Disorder
☐ Headaches ☐ Menstrual Cramps ☐ Frequent Colds
☐ Sleepwalking ☐ Frequent Ear Infections ☐ Surgical History of Consequence
☐ Diabetes ★ ☐ Fainting ☐ Other

Information about items above (attach additional information if needed): _________________

____

★Asthma, Diabetes or Anaphylaxis

Please complete the additional "Request for Information" forms and attach to this Health Form.

Forms can be downloaded from our website or available from your student's teacher.

Chronic Health Concerns: Check "True" or "False" for each statement.

1. This student has had chicken pox or has received the varicella immunization ………………………...……….... ☐ True ☐ False
2. This student has not had mononucleosis ("mono") during the past year …………….……….....……………….. ☐ True ☐ False
3. This student's hearing is within normal ranges …………………………………………………………….....…… ☐ True ☐ False
4. This student's sight is within normal ranges or s/he uses corrective lenses to remedy vision ………………….... ☐ True ☐ False
5. This student typically sleeps without snoring, sleep talking or making other noises ……………………...……. ☐ True ☐ False
6. This student is free from illness, injury or physical challenges that would affect participation ……………..... ☐ True ☐ False
7. For girls: this student knows about menstruation and/or has a normal menstrual history ……………………..… ☐ True ☐ False
8. This student has been in countries outside the United States in the past 9 months ……………………………..… ☐ True ☐ False
   If "True", list the countries and the length of time spent in each.

   Country: ___________________________________ Country: ___________________________________

   Dates: _____________________________________ Dates: _____________________________________

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

1. This student has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD ………………...……...…….. ☐ Yes ☐ No
2. This student has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder ………………………..… ☐ Yes ☐ No
3. This student has an emotional heath concern (specify) ………………………………………………...…………..… ☐ Yes ☐ No
4. This student has seen or is currently seeing a professional to address mental/emotional concerns ……………..…. ☐ Yes ☐ No
5. This student has had a significant life event that continues to affect the student's life ……………………………….. ☐ Yes ☐ No
   If "Yes", please provide information about the event – death of a loved one, family change, adoption, new sibling, survived a disaster – its impact upon your student's life, and care tips for their time at camp.

____

____

When We Need To Talk With You: We will certainly call in an emergency, but we'll also call if we have questions about your student's health. If we cannot reach you or your emergency contact at the numbers listed, please provide contact information for other people who know your student and with whom we can consult. We assume you have spoken to these alternative contacts and they are willing to assist should the need arise.

Alternate Contact __________________________________ Phone: __________________________ Relationship:

Alternate Contact __________________________________ Phone: __________________________ Relationship:

What Have We Forgotten to Ask? Provide additional information about your child's health that may have been neglected on these forms. We are particularly interested in information that has an impact upon your child's ability to fully participate in our program.

____

____

____

____

____

____

Page 3 of 4

Parent/Guardian Authorization

The information contained in this form is correct, as far as I know, and the child herein described has permission to engage in all camp activities except as noted. I understand that health/accident insurance coverage is the responsibility of the parent/guardian. I hereby give permission to YMCA Storer Camps to secure emergency medical, routine medical, surgical treatment, and non-surgical care for the child named on this form, while at camp. I also understand that the parent/guardian is fully responsible for the camper's transportation if he/she is dismissed for disciplinary, behavior or medical reasons. I absolve the YMCA of Greater Toledo/Storer Camps and all of its employees of any and all liability, financial and/or otherwise arising from administration of medication to my child under the terms of this release. YMCA Storer Camps is not responsible for payment of any medical expenses incurred during participation at camp.

In consideration for being allowed to participate in the YMCA's programs, I agree to assume the risk of such activities and programs, and I further agree to hold harmless the YMCA of Greater Toledo, it's officers, employees and representatives from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from injury or death, accident or otherwise, during or arising in any way from the activities. I grant permission for me or my child to participate in all planned camp activities including out of camp trips by van or bus, hiking or horseback riding. The YMCA is not responsible for lost, stolen or damaged personal articles. I also authorize the YMCA to have and use photographs, slides or video tapes of me, my child, or my family as may be needed for its public relations programs. I acknowledge that this General Release of Liability and Authorization for Treatment of the YMCA is binding on me personally and on my heirs, personal representatives, successors and assigns.

Limited Purpose Power of Attorney: Consent to Treatment of Minor (Must be signed by parents or legal guardians)

By signature(s) below, the undersigned appoints____ (School Name), to act alone, or delegate to another person, the power to consent on our behalf to all emergency treatment and/or medical care (except elective surgery) of (child's name) ______________________________________ determined to be necessary or desirable by our child's attending physician at the hospital.

This Power of Attorney shall continue through the participant's stay at camp, or until revoked by the undersigned, whichever is earlier. Physicians or the hospital's medical staff may assume and rely on this authorization being current and in effect during such period unless notified otherwise.

The undersigned certify that they read this Power of Attorney (or had it read to them), that they understand this Power of Attorney, and sign it voluntarily.

Note: If this form is being signed for a child or minor participant at the camp, it must be signed by both parents or legal guardians unless one is deceased, mentally incompetent, or has had parental rights terminated, or there has been a divorce, or parents are unmarried, the parent having physical custody of the child should sign. (The signing parent should understand the indemnification clause above defending YMCA Storer Camps against claims by other parties on behalf of the child.) If neither parent has parental rights, or both are deceased, this form must be signed by the legal guardian of the child. This agreement will be enforced in accordance with the law of the State of Michigan.

If there are not two parent signatures below, please indicate the reason why by checking the appropriate box.

- ☐ Missing parent is deceased.
- ☐ Missing parent mentally incompetent or has had parental rights terminated.
- ☐ Parents are divorced or unmarried and signing parent has physical custody of the child.
- ☐ Both parents are deceased and a legal Guardian is responsible for the child.
- ☐ Parental rights have been terminated and a legal Guardian is responsible for the child.

Father's or Legal Guardian's Signature: ____ Date: _________________________

Mother's or Legal Guardian's Signature: ____ Date: _________________________

❋ Health Office Use Only ❋

Date	Time	CHO	Notes

ANAPHYLAXIS
Individual Emergency Action Plan

Individuals with multiple anaphylactic responses should complete one form for each allergen.

Name of Child ____

Date of Birth:_____________________________________
Month Day Year

This child responds with anaphylaxis from____________________________________

School:__________________________________

About the Signs/Symptoms Experienced by this Person

Check those that apply to this child's anaphylaxis response. It is assumed that the severity of these symptoms can change quickly; some can potentially progress to a life-threatening situation.

- ☐ Itching of the lips, tongue and/or mouth.
- ☐ Swelling of the lips, tongue and/or mouth.
- ☐ Itching and/or sense of tightness in the throat.
- ☐ Hoarseness.
- ☐ Hacking cough; repetitive cough and/or wheezing.
- ☐ Swelling about the face.
- ☐ Hives; an itchy rash.
- ☐ Nausea, abdominal cramping, vomiting and/or diarrhea.
- ☐ Shortness of breath.
- ☐ "Thready" pulse; increased heart rate.
- ☐ "Passing out," fainting.

History

Does this child also have asthma?..............☐ Yes ☐ No

Can this child recognize when s/he is experiencing signs/symptoms of anaphylaxis?................ ☐ Yes ☐ No

When did this child last experience an anaphylactic response?

Date:____________________________

Describe what happened and how the person responded:____
____
____
____
____

ATTACH THIS COMPLETED FORM TO YOUR CHILD'S HEALTH FORM

Emergency Action Plan

Please note that YMCA Storer Camps is at least 20 minutes from definitive care.

Regarding an EpiPen®

Our expectation is that the child will bring at least one EpiPen®, carry that device on their person during their stay, and know how to use the EpiPen®.

Has this child ever administered the EpiPen® to themselves?..☐ Yes ☐ No

Our staff will help a child administer their EpiPen®if need arises.

Recognizing a Reaction

It is our expectation that this child will tell a staff member if s/he suspects s/he is having a reaction.

Parents: please instruct your child to do this.

Treating a Suspected Exposure

If an exposure is suspected, but no signs or symptoms of anaphylaxis are present, we will monitor the child for 20 minutes and take no further action unless signs/symptoms appear.

Treating an Anaphylactic Response

1. Assuming a patent airway, give 50mg diphenhydramine (e.g.Benedryl) by mouth. Remove child from contact with allergen if possible.
2. Inject 0.3 cc epinephrine stat; repeat dose as needed.
3. Call an ambulance; tell the ambulance crew that this is an anaphylaxis situation.
4. Contact parents per directions on child's health form.

If you physician wants a different protocol followed, have your physician legibly write that protocol on the back of this form followed by his/her signature and date.

Signature of Custodial Parent Or Legal Guardian:____

Printed Name:_______________________________________

Date Signed:____

Questions? Please Call: YMCA Storer Camps Health Services at: (517) 536-8607