OPWDD Regulated Program

Wagon Road Camp

431 Quaker Road, Chappaqua, NY 10514

914-238-4761 * Fax 914-238-0714

OVERNIGHT RESPITE ENROLLMENT FORM 2018/2019

Camper Information

Last Name First Name

Home Address (number and street) Apt. City State Zip

Date of Birth Gender Disability

Demographic Info: (optional)

Ethnicity: ☐ Hispanic or Latino ☐ No Response

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ No Response

Name of School: _____ Teacher: _____

Please check as applicable: Special Ed ☐ Yes ☐ No IEP ☐ Yes ☐ No English Language Learner ☐ Yes ☐ no

Parent/Guardian Information

Parent/Guardian #1

First Name (Please Print) Last Name

Home Address (number and street) Apt.
If same as camper above, check here: ☐

City State ZIP Code

Primary Phone (best number all hours) Secondary/Work Phone

Relationship to Camper

Parent/Guardian Email Address

Parent/Guardian #2 (if applicable)

First Name (Please Print) Last Name

Home Address (number and street) Apt.
If same as camper above, check here: ☐

City State ZIP Code

Primary Phone (best number all hours) Secondary/Work Phone

Relationship to Camper

Parent/Guardian Email Address

Emergency Contacts

Please identify TWO individuals OUTSIDE OF YOUR HOME who may be called if parents/guardians listed above are not available.

Full Name
If this person may also pick up your child, check here: ☐

Relationship to Camper

Primary Phone (Best number all hours) Secondary Phone

Full Name
If this person may also pick up your child, check here: ☐

Relationship to Camper

Primary Phone (Best number all hours) Secondary Phone

Child's Name_____

Medicaid Information

Care Coordination Org(CCO)): _____ Phone #:_____

Care Manager:_____
E-Mail

Medicaid #:_____ TABS #:_____ Medicaid Waiver: Yes ☐ No ☐

Consent Statement for Program Admission and Emergency Care

Admission: I affirm that I am the parent/guardian of the above named child, and I authorize Children's Aid to admit my child into Wagon Road Respite Program. My child may participate in all activities: swimming, horsemanship, high and low ropes course, sports, cooking, music, arts, hiking, professional guest performances, small group games & activities. I authorize staff to provide personal hygiene care as needed: showering, diaper changes, applying lotion, and/or monitoring self-care. I authorize staff to use camp provided soap/shampoo, sunscreen, and bug repellant for the care of my child. I authorize my child to have any of the lotions, sunscreens, or bug repellants that I send. I further more authorize the staff to use them on behalf of my child. I also authorize Wagon Road Staff to conduct a body check of my child at the beginning and at the end of each program.

If my child needs emergency medical or emergency dental care, and I cannot be reached, I give consent to The Children's Aid Society Wagon Road Overnight Respite Program to obtain the necessary emergency medical or emergency dental care for my child. I agree to pay all the costs associated with the emergency medical or emergency dental care that my child receives. I understand that every effort will be made to contact me before and after medical or dental care is provided**.**

This authorization applies unless I specify in writing that my child not participate in an activity.

Lost Articles: I understand that Children's Aid is not responsible for lost articles, and understand that it is recommended that items of great value are not brought to camp.

Parent/Guardian Name :_____(Please Print)

_____ / /

Parent/Guardian Signature **Date**

Admissions Guidelines & Reduction, Suspension, or Discontinuance of Services

WRC Respite Care is happy to offer services at our Children's Aid Camp located in the Chappaqua of Westchester County. Our staff includes experienced nurses and specially trained day camp staff. We are limited in our capacity and therefore unfortunately cannot serve youth who:

- Require physical intervention for general safety and well-being (e.g. youth with a history of running away/elopement, youth in need of monitoring with medical equipment, or are medically fragile)
- Participants who pose a risk to the safety and well-being of themselves or others (e.g. youth with behavior plans and require physical restraint.)

If a participant exhibits the behaviors noted above services are subject to reduction, suspension or discontinuance of services. An Overnight Respite Administrator will call to discuss the issues and the decision. That phone call will be followed by a letter that outlines the change and the reasons. Parents have the right to object to changes in service. The letter outlines that procedure that parents may take to object to the change in service.

I have read the Admissions Guidelines, Reduction, Suspension or Discontinuance of Services policy for Children's Aid Overnight Respite program and understand that I will be contacted if this applies to my child. I realize I have the right to object to any change in my child's service.

_____ / /

Parent/Guardian Signature **Date**

Child's Name_____

Medication Administration Regulations

NYS Regulations require that in order for the CA Wagon Road Overnight Respite Program to dispense **medication, OTC medications, medicated creams and vitamin/herbal supplements** to a consumer the following conditions must be met:

1. A completed Medication Authorization Form (Attached) with the parent and physician's signature.
2. Medications, delivered to Wagon Road Staff in the original prescription bottle featuring the consumer's name, the name of the medication, the name of the physician, the name of the pharmacy, and dosage/frequency information.
3. OTC medications, medicated creams, and vitamins/herbal supplements must be delivered in the original OTC packaging or bottle.
4. **All medications expire after one year. No medications will be accepted that are over one year old.**

Other Medication Regulations:

1. Doctor's orders are the standard by which medications are given at Wagon Road. Discrepancies between dosage procedures at home, the medication bottle, and the doctor's orders are resolved by following the doctor's orders.
2. At the time a consumer is confirmed for a program, the parent/guardian is responsible to update any doctor's orders that have changed the medication regimen by providing a written doctor's order.
3. Medications will not be accepted if:
   Delivered in inappropriate containers; Modifications to a medication bottle have been made, such as handwriting or changes to the label; Medications over a year old.

Certification:

I have read these regulations and understand that if they are not followed, medications cannot be accepted by the CA Wagon Road Overnight Respite Program. This will mean that my child will not be allowed to participate in the program.

_____ / /

Parent/Guardian Signature **Date**

Child's Name_____

Consent for Photo/Videotaping and Use of Youth Work

I grant permission to Children's Aid, its agents and employees, or media outlets working with Children's Aid, to take photographs, motion pictures, audio and/or videotape my child who I have registered for respite and to use my name and my child's name in connection with any Children's Aid publication or any news story in any medium, including printed publications, television, film, radio, web, Internet and/or any other electronic medium.

- I understand my child may be photographed, interviewed or otherwise recorded during program activities and special events and give permission for my child to be photographed, interviewed or otherwise recorded solely for non-profit, non-commercial purposes of the program.

  ___Yes, I give my permission ___ No, you do not have permission

- I understand that my child's work may be used in materials that promote programs, solely for non-profit, non-commercial purposes of the program.

  ___Yes, I give my permission ___ No, you do not have permission

_____ / /

Parent/Guardian Signature **Date**

Release of Information from School

Date:_____

To Whom It May Concern:

I,_____, grant release to _____
(Name of Parent or Guardian) (Name of Institute)

Phone #_____ to provide The Children's Aid Society's Wagon Road Overnight Respite Program with copies of all psychological, psycho-social, psychiatric, educational, anecdotal, medical and other relevant material concerning my child,

_____. I also release all staff from your institution to speak to
(Name of child)
Representatives of The Children's Aid Society's Respite Program regarding my child.

_____ / /
Parent/Guardian Signature **Date**

_____ / /
Translator, if applicable Signature **Date**

Overnight Respite Ropes Course Information

Over the year we will be involving consumers in ropes course activities.

Low Ropes Challenges: physical challenges that are from 1-2 feet off the ground like the Whale Watch or the low zip line swing. These activities are led by specially trained staff and organize to support campers balance.

For example, the Whale Watch is a group, platform teeter-totter. This apparatus can accommodate 12 adults standing on it. A challenge for campers would be to stand on the platform with a staff member and try to balance it. Depending on the camper and his or her abilities there may be 2 or 3 campers with 2 or 3 staff doing the challenge.

Child's Name_____

High Ropes Challenges: activities take place from 3 feet to 23 feet off the ground. They involve special harnesses, hardware, and climbing rope to provide a belay system to insure safety.

Examples of these activities are the Burma Bridge and the Trust Swing. The Burma Bridge is a climb up a tree of about 18 feet and a walk across a cable bridge. The Trust Swing is an activity that requires no climbing where a participant is lifted in the air by a team of staff and participants. A participant is fitted with a fully body harness, connected to a climbing rope that runs through a pulley secured to a cable 30 feet above ground. This is a challenge by choice activity and many campers like to stay about 5 feet off the ground and swing back and forth. Campers in wheel chairs can be put in the harness while they sit in their chairs and lifted into the air from their chairs. In order to deal with any communication barriers, we pay close attention to the behavior and expressions of each non-verbal camper to see if they want to do it, and how high they want to go.

Your signature below grants Wagon Road Camp permission to involve your child in these activities.

_____ / /
Parent/Guardian Signature **Date**

Child's Name_____

Consumer Care Updates

Please list below any changes in the care of your child or specific care instructions you want us to have.

A. Self-Care/ Hygiene: No Changes ☐ Changes ☐
Please Detail:

B. Communication: No Changes ☐ Changes ☐
Please Detail:

C. Toileting: : No Changes ☐ Changes ☐
Please Detail:

D. Eating: : No Changes ☐ Changes ☐
Please Detail:

E. Sleeping: : No Changes ☐ Changes ☐
Please Detail:

F. Habits: : No Changes ☐ Changes ☐
Please Detail:

G. Behavior: No Changes ☐ Changes ☐
Please Detail:

H. Appliances: No Changes ☐ Changes ☐
Please Detail:

Food Allergies or Dietary Restrictions

Does your child have any food allergies or restrictions? Yes ☐ No ☐
If yes, please specify:

Child's Name_____

Recurring Self-Injurious Behavior

Does your child have any behaviors that cause self-inflicted injury? Yes ☐ No ☐
If yes, please describe:

Seizures

Does your child have seizures? Yes ☐ No ☐
If yes, please describe what they look like and when they are more likely to happen.

Medications

Medications are given according to written doctor's orders. Please note below any special procedures to give medications to your child.

Medical Form 2018/2019 Page 1 of 2

Child's Name:_____ Date of Birth:_____

Note: The purpose of this form is to provide the staff with pertinent information, which will service the needs of the camper in Wagon Road Summer Camp. **Physician must sign this form.**

Immunization History: Fill in or attach record	Dates
DTP Series	
Booster	
Tdap	
Polio	
MMR	
Hepatitis A	
Hepatitis B	
Meningococcal Vaccine	
Varicella (Chicken Pox)	

Medical Examination: Filled out by licensed Physician/Nurse Practitioner.				Code: S=Satisfactory X=Non Satisfactory (explain)			
General Appearance:							
Height: Weight:				Blood Pressure:			
	Code		Code		Code		Code
Posture & Spine		Throat & Tonsil		Eyes		Vision	
Glasses		Extremities		Heart		Ears	
Hearing		Feet		Lungs		Skin	
Nose		Teeth		Abdomen		Hernia	
Genitalia							

Asthma? Yes ___ No ___ Status:_____

Allergies: _____

_____

Seizures? Yes ___ No ___ Status: _____

EPI Pen Need? Yes ___ No___

Other Medical/Behavioral Problems: _____

Abnormal Findings or Handicapping Conditions: _____

Physical restrictions while in camp? Yes___ No___

Restrications:_____

Special Diet:_____

General Appraisal:_____

I have examined the person herein described, review his/her health history, and it is my opinion that he/she is physically able to engage in Day Camp activities (except as noted above).

Signature: _____ Date of Exam: _____

Examining Physician/Nurse Practitioner

Address and Phone: _____

In order for medications to be administered to participants this document must be fully completed and **signed by both the parent and physician. The Following Rules must be followed:**

All prescription, over the counter (OTC) medications, medicated creams & vitamins/herbal supplements provided by the parent require both doctor's orders and parent permission.

All items must be delivered to camp in the original pharmacy or OTC containers.

All prescription, OTC medications medicated creams & vitamins/herbal supplements must be current and unexpired.

Name of Participant: _____Date of Birth: _____

Parent's Name: _____ Primary Phone #:_____

Physician's Name: _____ Primary Phone #:_____

I give permission for the onsite medical designee to administer the following medications for the above named participant.

Medication/OTC/Vitamin Supplement/ Cream	Condition Treated	Dosage	Route	Frequency/Time	Conditions for PRN

Below is a list of OTC medications available for participants at camp. Indicate below which can be given to the above named participant.

OTC Medications	Dosage	Route	Schedule	Conditions for PRN	**Indicate below**	
Tylenol 325mg.	Per label by age/weight	Orally	Q 4 hr. pm	Pain or Fever > 100 F	**Yes**	**No**
Motrin 200mg.	Per label by age/weight	Orally	Q 6 hr. pm	Pain or Fever > 100 F	**Yes**	**No**
Mylanta 15cc	Per label by age/weight	Orally	Q 4 hr, no> 3/24 hr	Minor GI Discomfort	**Yes**	**No**
Tums Tablets	Per label by age/weight	Orally	Q 4 hr, no> 3/24 hr	Minor GI Discomfort	**Yes**	**No**
Calamine Lotion	Affected area	Topical	Q 2-4 hr, prn	Itching Rash	**Yes**	**No**
Aloe gel	1 Packet for affected area	Topical	Q 2-4 hr, prn	Sunburn Discomfort	**Yes**	**No**

Parent's Signature_____ Date: _____

Physician's Signature: _____NYS License #_____ Date: _____

Children's Aid-Wagon Road Camp, 431 Quaker Road, Chappaqua, NY 10514
Phone: 914-238-4761; Fax 914-238-0714; e-mail: janetl@childrensaidnyc.org

REQUEST PROTECTED HEALTH INFORMATION FROM: ___ Provider ____ Hospital ____ Health Center

To:_____ Telephone:_____
(Name of provider doctor/hospital/health center)

Address:_____

Patient's Name:_____ Date of Birth:_____
AKA:_____ Today's Date: _____

Request Authorization: I, _____, the patient/parent/legal guardian, am authorizing the requested health information as indicated below to be released to:

Children's Aid-Wagon Road Camp

Requesting the Following Health Information: By signing this authorization, I authorize the protected health information for the above named patient as follows:

- ○ All health information for the above named patient.
- ○ Dates of service of service type:_____
- ○ Only specific health information Indicated:_____
- ○ Specifically for the following purpose:_____

I choose not to Indicate the reason I am authorizing the release of health information. (This box may NOT be checked If the Information to be used or disclosed containing information on alcohol or drug abuse Identity, diagnosis, prognosis or treatment).

This Authorization Expires on O Date _____or O Conclusion of a specific event (identify the event) _____

IMPORTANT INFORMATION

1. I understand that the Provider cannot guarantee that the Recipient will not redisclose my health Information to a third party. However, if the information received regarding treatment information about a client in a federally-assisted alcohol or drug abuse program, The Children's Aid Society is prohibited under federal law from making any further disclosure of such information unless further disclosure *is* expressly permitted by my written consent or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
2. I understand that I may revoke this Authorization in writing at any time. However, revoking this authorization will not affect any previously authorized disclosure or use.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the request of the health information:

☐ Authorized Signature:. _____ _____Date:. _____
Print Full Name:_____
Home Address:_____
Telephone#:_____

When the client is not competent to give consent, the signature of a parent, legal guardian, health care agent (proxy) or other representative is required.

☐ Signature of legal representative:_____ Date:_____
Print Full Name:_____
Home Address:_____
Telephone#:_____

Relationship to representative to client: _____ _

OPTIONAL:
o Photo ID of signatory (attach a copy) o Witness:_____ o Copy of authorization to the client

Children's Aid ls not responsible for any charges concerning copying and/or handling of health information.