Children's Aid
Every step of the way
Wagon Road Camp 431 Quaker Road, Chappaqua, NY 10514
Phone: 914-238-4761 FAX: 914-238-0714 Cell: 917-634-6616

Respite Program Special Consent 2022

Safety of our staff and campers is our highest priority; these changes to our pandemic plan include additional safety measures based on our most recent understanding of COVID-19 virus transmission. Please note that caregivers must consent to these additional COVID-19 precautions in order for their children to continue participation in the program.

We continue to follow our original safety guidelines, based on 2020 DOH guidance on operating camp. So far, the basic guidelines we've implemented have shown to be successful—frequent handwashing and preventing groups from mixing do minimize the risk of COVID-19 spread. Going forward we will continue to follow our original protocols, which include:

- Campers and staff will operate in stable groups. Once in a group, campers and staff may not change groups, except for in cases of absolute necessity; there can be no mixing of groups at any time.
- Campers and staff will frequently wash or sanitize their hands. Staff will frequently disinfect surfaces and high-touch areas like bathrooms and dining tables.
- The camp is set up to allow for social distancing. We will monitor the movement of campers throughout Wagon Road to reduce congestion when campers transition during programming.

The use of face coverings will now be encouraged whenever possible, especially when in indoor programming spaces. Staff will use face coverings during all close contact with campers, particularly when assisting campers in their hygiene routines. Programming spaces, mealtimes, and sleeping arrangements will be set up to allow for physical distancing to prevent unnecessary close contact between campers.

Conditions:

1. All staff are required to be vaccinated against COVID-19. At this time, vaccination of campers is not required, but highly encouraged. According to all medical science, vaccination is the most effective way of preventing serious illness from the COVID-19 virus.
2. Campers who are not yet vaccinated must show evidence of a negative PCR COVID-19 test (cannot be a rapid antigen test) performed within 72 hours of arrival to camp/bus pickup location.
3. All campers and staff, regardless of testing or vaccination status, must also complete a rapid antigen test upon arrival to camp or the bus pickup location. Any staff that leave camp and return throughout the session must submit to testing before returning to their designated group.
4. Campers must complete a screening upon arriving at camp/bus pickup location to determine whether they're eligible to attend, based on whether they've:
    - Knowingly been in close or proximate contact with anyone who has tested positive or has/had any symptoms of COVID-19 in the past five (5) days.
        - Exception for fully vaccinated AND boosted asymptomatic campers and staff, or those who have recovered from laboratory confirmed COVID-19 in the previous three (3) months and has not been placed in quarantine.

    - Tested positive through a diagnostic test of COVID-19 in the past 10 days.
    - Experienced any symptoms of COVID-19, including a temperature of greater than or equal to 100ºF.
5. On the bus:
    - Campers and staff will be boarded from back to front in order to minimize exposure.
    - Campers will be spaced apart from one another to the greatest extent possible; siblings will be placed together.
    - All individuals must wear a face covering while on the bus—this includes the driver, staff, and campers.
    - Ventilation within the bus will be increased if the weather permits, by opening the top hatch of the bus and opening all windows.
6. Each day at camp, all campers and staff will undergo a health screening to check for symptoms of potential illness. Anyone suspected of having COVID-19, or that has a temperature of greater than or equal to 100ºF, must immediately be separated from others, brought to the camp infirmary, and given a rapid test.
7. Each day at camp, 20% of campers and staff will undergo randomized rapid testing to ensure safety in each of the pre-determined stable groups. This means your child may be tested again at some point throughout their stay at camp.
    - Initial here to indicate consent to administer COVID-19 testing for your child: _____
8. If an individual tests positive, arrangements must be made to remove the individual from campus, either through pick-up by a parent or drop-off by the Camp Director or Program Director in the camp van. Wagon Road Camp's administrative staff will immediately notify the state and local health department about the positive case.
    - Initial here to indicate that you will be available to receive your child (or make necessary arrangements) should they need to be removed from campus: _____
    - All individuals that had contact with the positive individual must also be tested; the stable group can quarantine together while awaiting test results. Quarantine together means remaining in their assigned cabin and not utilizing shared program spaces in order to prevent/minimize risk of exposure to other groups. Meals and activities will be completed in the cohorts' cabin.

While these practices are all consistent with Department of Health guidance and we will do our best to keep your child safe from COVID 19, we cannot promise or guarantee that this or any other pathogen will not enter Wagon Road. Participating in the camp program means there will always be a risk of your child becoming ill with COVID or possible other communicable disease. We want you to be fully aware of this risk in deciding to send your child to camp, and that you are willing to accept and assume this risk on your child's behalf.

- I have chosen to have my child attend Wagon Road Camp's Overnight Respite Program. I understand that participating in the Camp's activities may place my child at greater risk of contracting COVID-19, that my family has discussed this risk, and are willing to assume this risk.
- I acknowledge and agree that we waive all rights and will hold Children's Aid harmless for any resulting illness or death due to COVID-19.

_____ _____

Signature Date

_____

Caregiver Name

Children's Aid
Every step of the way

Wagon Road Camp
431 Quaker Road, Chappaqua, NY 10514
Phone: 914-238-4761 | Fax: 914-238-0714
E-Mail: cayala@childrensaidnyc.org

OPWDD Regulated Program

please note, the most secure form to transmit personal information is through fax or regular mail; unencrypted e-mails are not HIPAA complaint. By choosing to e-mail these forms to us, you are assuming responsibility for your child's personal information*

OVERNIGHT RESPITE ENROLLMENT FORM 2021/2022

Camper Information

Last Name **First Name**

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

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: _____
Full Name **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**

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**

Child's Name_____

Release of Information from School

Date: _____

To Whom It May Concern:

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

_____ - _____ to provide
(Name of Institute) **(Institute Phone #)**

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 representatives of
(Name of child)

The Children's Aid Society's Respite Program regarding my child.

_____ / /
Parent/Guardian **Date**

_____ / /
Translator Signature, if applicable **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.

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 below:

B. **Communication:** ☐ No changes
☐ Changes – Please detail below:

C. **Toileting:** ☐ No changes
☐ Changes – Please detail below:

D. **Eating:** ☐ No changes
☐ Changes – Please detail below:

E. **Sleeping:** ☐ No changes
☐ Changes – Please detail below:

F. **Habits:** ☐ No changes
☐ Changes – Please detail below:

G. **Behavior:** ☐ No changes
☐ Changes – Please detail below:

H. **Appliances:** ☐ No changes
☐ Changes – Please detail below:

Child's Name_____

Food Allergies or Dietary Restrictions

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

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:

Medications

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

Medical Form 2021/2022 Part 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:** **Fill in or attach record**
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___ **Restrictions:** _____

_____

_____

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: _____

Medication Authorization Form 2021/2022 Part 2 of 2

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: _____ Date: _____

Physician's NYS License #_____

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

- o All health information for the above named patient.
- o Dates of service of service type:_____
- o Only specific health information indicated: _____
- o Specifically for the following purpose: _____
- o 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 is not responsible for any charges concerning copying and/or handling of health information.