CAMP MAHICAN APPLICATION
2020

Applications can be sent to:
COARC – Camp Mahican
PO Box 2
Mellenville, NY 12544
Phone 518-828-3890 Ext 2502

FOR ID PURPOSES PLEASE ATTACH PHOTO HERE

FULL FACE COLOR PHOTO

NO PHOTO COPIES

PLEASE PRINT CLEARLY IN BLOCK *LETTERS* –
INCOMPLETE APPLICATIONS WILL BE RETURNED.

Camp Application Deadline: Friday, June 12, 2020
Camp Schedule for 2020 – Monday, July 6th – Friday July 31st

*** CHECK OFF DESIRED WEEK OR WEEKS**
- □ **1 -- JULY 6 TO JULY 10**
- □ **2 – JULY 13 TO JULY 17**
- □ **3 – JULY 20 TO JULY 24**
- □ **4 – JULY 27 TO JULY 31**
- □ **5 – OTHER _____ (THESE DATES ONLY)**

Is there any time during the summer your child will not be at camp because of vacation, scout camp, etc?
Please indicate dates: _____

***Camp APPLICANT'S NAME: _** **SEX: M F**

***SOCIAL SECURITY NUMBER:**			
***Does applicant have Medicaid?** □ **NO** □ **YES** ***Medicaid #:**			
***Date Of Birth:**	**AGE:**	**HT:**	**WT:**
***Primary disability:** You **must** attach any documentation that provides proof of disability eligibility i.e. ISP,IEP or Psychological evaluation	ID/DD	Autism	Other:

□ *****MOTHER'S FIRST AND LAST NAME:
□ OR *GUARDIAN*

□ *****FATHER'S FIRST AND LAST NAME:
□ OR *GUARDIAN*

GUARDIAN: RELATIONSHIP TO APPLICANT

□ **PARENTADDRESS**: (# AND STREET)
□ OR *GUARDIAN*

Address (CITY) State Zip

***PHONE#**	**MOTHER**	**FATHER**	**GUARDIAN**
HOME	( )	( )	( )
WORK	( )	( )	( )
CELL	( )	( )	( )

PARENTS: **DIVORCED**: □ YES □ NO **SEPARATED**: □ YES □ NO **WIDOWED**: □ YES □ NO

CUSTODIAL PARENT'S NAME:

Insurance

*Does the child have Health Insurance? _____ Yes _____ No		
Carrier:	Group#	Medicaid #:

*TRANSPORTATION –BUS STOPS

(Please check the pick-up/drop-off point closest to your home)

HUDSON	KINDERHOOK/CHATHAM
_____ Front Street Firehouse	_____3143 Route 9 Valatie NY (COARC Evergreen Hall)
_____ Hudson Library	_____ Price Chopper in Chatham
_____ Greenport Fire House-Pumper Station #1	_____ Philmont Cumberland's
_____ Route 23 (Claverack School)	_____ Martindale Diner
_____ Coarc Germantown IRA	
_____ I will be transporting my child to camp	

*** Bus Stop Authorization**

Please check the arrangement that applies to your child.

_____ Parent/Guardian will be at the bus stop.

_____ I have arranged with another person to supervise my child at the bus stop:

* Name of Person: _____

_____ My child may walk to and from the bus stop with my permission.

_____ Other (please specify): _____

_____

*Parent/Guardian Signature Dat4

<u>*TRANSPORTATION PICK UP</u>

List all persons who have permission to pick up the camper from the bus stop or camp.

* Identification **will be** requested from anyone picking up your child.

* **The camper will not be allowed to leave with any other person unless a written note signed by a legal guardian listed on this application is received by the Camp Director. (Phone calls will be accepted only in emergencies). A written note is also required if the camper needs to change bus routes, temporarily or permanently. <u>This Policy Will Be Strictly Enforced.</u>**

****The following people may pick up the camper from bus stop or camp:**

1. Name _____
   Phone _____
   Relationship to Camper _____

2. Name _____
   Phone _____
   Relationship to Camper _____

3. Name _____
   Phone _____
   Relationship to Camper _____

***<u>EMERGENCY CONTACT</u>**: Please list one (1) contact who can take responsibility **<u>ONLY</u>** if parents or Guardian are unavailable. (Please inform the individual(s) Camp Mahican may call.)

Name	Relationship:
Home Phone #: ( )	
Cell Phone #: ( )	Work Phone #: ( )

SERVICE COORDINATION / CASE MANAGEMENT

Name of Agency	NYS TABS ID Number
Case Manager's Name	Case Manager's Telephone Number
Street Address	
City, State, Zip	

RELEASES NEED TO BE COMPLETED FOR ALL CAMPERS

<u>SCHOOL/DAY PROGRAM RELEASE INFORMATION</u> (MUST BE SIGNED AND COMPLETED)

Permission is hereby given for Camp Mahican, to request information from any school, training program, hospital, clinic or institution that the applicant is now attending.

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

***THE FOLLOWING INFORMATION MUST BE COMPLETED:**

School, Day Program currently attending:_____

Supervisor, Activity Coach or Teacher: _____ Phone Number: _____
Address: _____

Street City State Zip

* **Is your child eligible for free or reduced school lunch?** □ Yes □ No

*** <u>SKILLS AND ABILITIES</u> (Check (√) <u>all</u> boxes that apply)**

TOILET TRAINING:

☐ Fully trained ☐ Not trained ☐ Time trained ☐ Needs reminding ☐ Wears diapers
☐ Needs physical assistance

What type: _____

If time trained, give schedule:

_____

DRESSING:

☐ Independent ☐ Needs help ☐ Must be dressed

Needs help with ☐ Snaps ☐ Zippers ☐ Buttons ☐ Buckles ☐ Shoelaces

How do you help?

_____

HAND WASHING:

☐ Independent ☐ Needs help ☐ Must be washed ☐ Needs reminding

How do you help?

_____

EATING:

☐ No problem ☐ Needs help ☐ Must be fed
☐ Uses specialized eating equipment (describe):

_____

List favorite foods:

_____

_____

List foods disliked:

_____

_____

Does he/she tend to overeat? ☐ Yes ☐ No

If yes, how can we reduce this tendency?

_____

SPEECH:

☐ Speaks clearly ☐ Hard to understand ☐ Needs prompting ☐ Non-verbal
☐ Uses sign language If signs are used, please attach a list of all signs used and/or understood.

*** AMBULATION:**

☐ Walks freely ☐ Walks with difficulty ☐ Must be helped ☐ Does not enjoy walking
☐ Walker ☐ Wheelchair (**Maximum weight limit 140 lbs**)

*** HAZARDS:**

☐ Is aware ☐ Has to be reminded ☐ Needs constant supervision

* Does he/she have any tendency to wander away? ☐ Yes ☐ No

If yes, when and why?

_____

Has there been a significant behavior change, either positive or negative, in the past year. If so, please describe:

_____

_____

Does the applicant have any physical ailments, fears or anxieties that might be heightened by being away

from home? If so, what are they and how should we deal with them?

_____ _____

How does he/she act when upset? (strike out, cry, bite, withdraw, etc.):

_____

How do you ease upset feelings?

_____

How do you reward good behavior?

When would he/she act aggressively?_____

Describe aggressive behavior:

_____

_____

Is he/she involved in a behavior modification program at school and/or at home: ☐ Yes ☐ No

If yes, please describe it:

_____

_____

At what level does he/she comprehend directions?

( ) Can follow through on 4 or more step directions
( ) Can follow directions involving 2 or 3 steps
( ) Can follow directions involving 1 simple command

Please give us suggestions or recommendations to help our staff provide an enjoyable camp experience for your son or daughter.

_____

_____

What activities does he/she like? _____

_____

What activities does he/she dislike? _____

_____

Are there any activities your child cannot participate in due to physical, social, or religious reasons?
☐ Yes☐ No
If yes, please describe:_____

What difficulties might he/she experience in:

Relating to authority figures: _____

Relating to peers:_____

Cooperating in group activities:_____

Cooperating with medical personnel: _____

How best to work with these difficulties: _____

Please give us the names and relationships of family members who are important to the applicant. (Include pets, if appropriate.) _____

_____

Medical packet

Campers Name:

MEDICAL PACKET DUE → **June 12, 2020**

Dear Parent(s)/Guardian(s):

Please submit the following to help us create the required camp medical packet for the summer 2020.

1. ☐ This check-in form.
2. ☐ Camp Medical Addendum
3. ☐ Full face passport or wallet size photo (original photo)
4. ☐ Insurance card copies (front and back)
5. ☐ Copy of Specialized Eating/Nutrition Guidelines
   ☐ **Not** applicable
6. ☐ Copy of Adaptive Equipment Guidelines
   ☐ **Not** applicable
7. ☐ *Most recent Medical/Physical Exam (dated no earlier than 8/1/19)
   CHOOSE ONE OF THE FOLLOWING:

   ☐ Copy of Camp Mahican 2019 Medical Exam
   ☐ Copy of non-Camp Annual Physical Form
   ☐ Awaiting Medical appointment on _____
   for new physical exam and will forward a copy no later than one week after the exam.

8. ☐ 2020 Camp Authorization for PRN Med Administration
   ☐ Awaiting medical appointment as above will submit with medical paperwork.

9. ☐ Copy of full Immunization Record.
   (Required by New York State for anyone 21 years or younger)

Camp Mahican
Phone 518-828-3890 Ext 2503

Camp Mahican
*** Permission Form for Administration of Prescription Medication**
(Form Needs To Be Completed By Physician)

If your child will be receiving medication during camp hours, please sign the release below for our staff to administer this medication to your child. I give permission to the Coarc Camp Mahican Program staff to administer the below-named medication(s) to my child _____(child's name). I agree to send the medication in the **original prescription bottle,** labeled with the child's Complete name, and original label directions.

_____ _____
Parent or guardian signature date

Medication Name	**Dosage**	**Time to Be Administered**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circumstances (if any) under which medication(s) must not be administered:

Medication Name: **Circumstances:**

_____

_____
The medication(s)is/are being prescribed because:
_____

*******IMPORTANT Signature Required******

Physician's Signature: _____ Date: _____

STANDING ORDERS

(Form Needs To Be Completed By Physician)

Campers Name: _____

Please fill-in below the non-prescription medications, which may be given for the stated purpose during day camp hours to the above named person. Please **specify** the appropriate dose.

Medication:	Used for:	Age range:	Not to exceed how many doses?	Yes	No
Children's Tylenol Liquid	Fever reducer, pain reliever	For ages **2 years to 11 years**			
Tylenol 325mg Pill/Capsule	Fever reducer, pain reliever	For ages **12 years and older**			
Pepto-Bismol Liquid/Pill	Relief of Heartburn, indigestion, upset stomach, nausea, diarrhea	Children under 12 years, ask doctor Children over 12 years, as directed			
Sunscreen Lotion	Prevention of sunburn	All ages			
Triple Antibiotic Ointment	Helps prevent infection in minor cuts, scrapes, and burns	All ages			
Solarcaine Antiseptic Gel/Spray	Temporary relief of pain and itching of minor cuts, scrapes and minor burns	All ages			
Calamine Lotion	Dries the oozing and weeping of poison ivy, poison oak, and poison sumac	All ages			
Saline Eye Wash	Help relieve irritation, discomfort, stinging, itching, loosen foreign material	All ages			

Special Instructions:

_____

_____

_____

__

Allergies:

_____

_____

_____ _____

Physicians Signature **Date**

Is Primary Diagnosis ☐ yes ☐ no Mild ☐ Moderate ☐
Severe ☐
Intellectual Disability If no, please list: ______________________________________

Secondary Diagnosis: Please List:

Asthma ☐ yes ☐ no Nebulizer treatment: ☐ Daily ☐ Sometimes ☐ Never

Inhalers: ☐ Daily ☐ Sometimes ☐ Never

Allergies to Food ☐ yes ☐ no Please List:
Environment ☐ yes ☐ no
Medication ☐ yes ☐ no
Epi Pen required: ☐ yes ☐ no

Respiratory Difficulties: ☐ yes ☐ ■❑ Requires Oxygen treatment:
☐ All the time ☐ Occasionally ☐ Never

Requires CPAP, BiPap or other treatment during nighttime:
☐ Yes ☐ No

Arthritis ☐ yes ☐ no Medications ☐ yes ☐ no

Constipation ☐ yes ☐ no Requires suppository ☐ yes ☐ no
Enema ☐ yes ☐ no

☐ Routinely ☐ Sometimes ☐ Never

Diabetes ☐ yes ☐ no Oral medications ☐ yes ☐ no
Insulin injections ☐ yes ☐ no

Requires blood glucose monitoring (MD order needed)
☐ Daily ☐ 2 times/day ☐ 3 times/day
☐ 4 times/day ☐ Monthly ☐ Other

Bowel Incontinency ☐ yes ☐ no Requires incontinence protection
Urine Incontinency ☐ yes ☐ no ☐ At all times ☐ At night only ☐ Sometimes ☐ During Transport

☐ catheter ☐ Independent ☐ Needs assistance

Epilepsy/Seizure Activity ☐ yes ☐ no Date of last seizure: ______________________________________
Type of seizure activity: ____________________________________
Has seizures:
☐ Daily ☐ ⌖♏♏🙰●⍓ ☐ Monthly
☐ 🏱⧫♒♏❒💻
♉♉♉

Frequent Ear Infections ☐ yes ☐ no Wears ear plugs when: ☐Shower ☐ 💧⬥♓❍❍♓■♑

☐ Both ☐ Never

High Blood Pressure ☐ yes ☐ no Requires blood pressure monitoring:
☐ More than once a day ☐ Daily
☐ Twice a week ☐ Once a week

Hepatitis (infectious) ☐ yes ☐ no Type:

Heart Disease ☐ yes ☐ no If 'Yes' provide diagnosis:

GENERAL MEDICAL INFORMATION (continued)

GENERAL MEDICAL INFORMATION

NAME: _____ ***To be completed by Parent or Guardian**

Hearing difficulty ☐ yes ☐ no	☐ Total hearing loss ☐ Severe loss ☐ Mild loss ☐ Right ear only ☐ Left ear only ☐ Both ears
Wears hearing aid: ☐ yes ☐ no	☐ All the time ☐ Sometimes ☐ Never
Stomach problems ☐ yes ☐ no	Describe:
Swallowing Difficulty ☐ yes ☐ no ☐♁♒☐☐☐♏♎☎♁♏♒♋■♓♍♋●◑	Special Diet ☐Ground ☐♑◆❒♏♏♎
❄♒♓♍&♏■♏♎ ●♓❑◆♓♎♦ ♍☐■♦♓♦◆♏■♍🖂 ☐↗💻 ☐ ☠♏♍♦♋❒ ☐ ♀☐■♏🖂 ☐ Pudding	
♦☐☐☐■ ☐ Cup	Adaptive Equipment: ☐Plate ☐ Describe Type:
Vision – Normal ☐ yes ☐ no	☐ Legally Blind ☐ Partially blind ☐ Right Eye ☐ Left eye ☐ Both eyes Wears corrective lenses: ☐ All the time ☐ Sometimes ☐ Never
Osteoporosis (bone disorder) ☐ yes ☐ no	Explain:
Period/ Menstrual Difficulties ☐ yes ☐ no	Menses occur every _____ days.
Period, Irregular, painful ☐ yes ☐ no	Date of last menses cycle:_____
Any recent injury ☐ yes ☐ no Illness ☐ yes ☐ no Hospitalizations ☐ yes ☐ no History of Falls ☐ yes ☐ no	Please give details:

* Person completing form:_____ Date: _____

Camper medical Addendum

Camper's Name: _____

Week Attending Camp

1 ☐ 2 ☐ 3 ☐ 4 ☐

Date of Birth: _____ / _____ / _____

Camper resides with:

☐ Parents/Guardian ☐ Other:_____

Parent/Guardian Information

Name:_____

Address_____

Home phone ( ) _____

Mobile phone ( ) _____

*** CONSENT FOR EMERGENCY MEDICAL TREATMENT/MEDICATION ADMINISTRATION**

In the event that _____ requires emergency medical treatment and the parent or legal guardian cannot be reached, the staff of Camp Mahican, Coarc, is hereby authorized to sign for permission for treatment. I also give permission for the administration of medication while at Camp.

Parent _____

Date: _____

Legal Guardian _____

ATTACH COPIES OF THE CAMPER'S INSURANCE, MEDICAID, OR MEDICARE CARDS.

F R O N T

B A C K

*** SWIM RELEASE** ***IF APPLICANT DOES NOT WISH TO SWIM, PLEASE CHECK BOX*** ☐

Swimming Permission

Below is a Swimming Permission section to allow your child to participate in any swimming activity at Camp Mahican. If this section is not completed, your child **will not be allowed in the water**.

I give permission to my child to participate in the swimming program at Camp Mahican.

Campers Name: _____

Signature of Parent or Guardian: _____

Date: _____

If your son/daughter has, a seizure disorder and you would like him / her to swim Without a lifejacket, a letter must be included with this application stating this intention.

IN COMPLIANCE WITH NEW YORK STATE PUBLIC HEALTH LAW, Camp Mahican is certified by the New York State Department of Health, which inspects the camp at least twice yearly. At least one inspection is made during the time the camp is in operation. Staff counselors receive training prior to the opening of camp season. Medical services are provided as required when pre-arranged. Emergency medical services are readily available. Nursing services are available. Waterfront activities are supervised by Progressive Swim Instructor staff. There are periodic fire drills to ensure adequate fire safety. Meals, when provided at special events, are well balanced and nutritious. Anyone wishing to review emergency medical, swimming and fire plans may arrange to do so with the Camp Director.

*It is understood by me, the _____ (Parent/Guardian of Camper) of _____ (Child's name) that I wish him/her to attend the Summer Day Camp Program, certified by the New York State Department of Health and conducted by the Coarc, its agents and authorized personnel at camp.

*Signature:_____Date: _____

Interviews may be held prior to final acceptance of your application.
Please attach any documentation that provides proof of disability eligibility

CAMP MAHICAN ANNUAL MEDICAL EVALUATION FORM

Childs Name:	
Date of Birth:	
Date of Exam:	

MEDICAL HISTORY

Medical Issues _____
_____
_____
_____
_____

Seizure's type _____
Frequency _____
Last seizure_____

Surgical/Date _____
_____
_____
_____
_____
_____

Psychiatric Issues _____
_____
_____
_____
_____
_____

Medication:	Dose and Frequency:	Route:	Desired Effect:

EMERGENCY MEDICATION PROTOCOLS
(i.e. for Breakthrough seizure: activity or behavioral issues)

Seizure Cluster /Behavior	Medication	Doses, frequency	Route	Special Considerations

CAMP MAHICAN

* Physical Examination Report

Childs Name:		BP:	
Date of Birth:		Pulse:	
Date of Exam:		Resp:	
		Temp:	

Skin:
Head/Neck/Thyroid:
Nose/Throat:
Eyes/Vision: Right Left Corrective Lenses: ☐ yes ☐no
Ears/Hearing: Hearing Aids: ☐ yes ☐ no
Dentition: Dentures : ☐yes ☐no
Neuro/Behavioral: Seizures: ☐yes ☐no
Cardiac: EKG Abnormalities:
Chest/Breast Exam: Mammogram Abnormalities:
Pulmonary:
Abdomen/GI:

MANTOUX DOCUMENTATION:
(Required for persons age 21 and older)
Date admin._____ site_____
Date Read _____ size _____mm
Interpretation_____
History of Positive Mantoux ☐ yes ☐ no
Chest X-ray ☐ indicated date _____
Results_____
☐ not indicated, asymptomatic

MOBILITY LIMITATIONS/RESTRICTIONS:

Activity	OK	Avoid	Limit	Describe Limit
Walking	☐	☐	☐	_____
Kneeling	☐	☐	☐	_____
Pulling	☐	☐	☐	_____
Pushing	☐	☐	☐	_____
Reaching	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lifting	☐	☐	☐	_____

DIETARY GUIDELINE/RESTRICTIONS:
Diet:_____
_____
_____
_____

ADAPTIVE EQUIPMENT/SCHEDULE OF USE:
_____
_____

Recto/Procto:
Renal/Urinary:
Genitalia/Gynecological: Pap Smear Abnormalities:
Back/Spine/Extremities:

_____

MD signature Date

Physician Name: _____
(Print)
Address: _____
_____

Telephone # ( ) _____

*PLEASE ATTACH copy of the Immunization Record * (Required for persons age 21 and younger)