



We will not process applications missing the required documents.

- **Speak to your Care Manager if you are going to use self- direction. CAMP WILTON IS NOT A WAIVER FUNDED PROGRAM. Campers seeking to use waiver funds will need to pay the \$275.00 camp fee prior to attending.** We do not have a DOH certificate.
- **A history/physical examination, completed by a licensed medical professional, is required.** The exam must be within 12 months of attendance of the session to be attended. Attach a copy of the Progress Notes, if applicable. **Must include a current list of medical diagnosis, med orders, med lists, diet lists.**
- **If the camper is waiting to get an updated physical exam, please include a copy of the 2022 or most recent exam available so we can process the application and send the new exam prior to camp.** Please include physician orders, medications, diet, and treatments.
- **Campers are not accepted until they receive a confirmation packet for a specific session.** The packet is sent to the address indicated in the camper personal information section. Please make sure that we have complete phone numbers, email and postal addresses, including zip codes, for sending acceptance letters and camper evaluations.
- **Please provide the name, phone number (including area code) and email address of the care/service coordinator for communication.**
- We cannot accept ANY emailed or faxed applications or documents. Please send to the Care Lane address listed below.
- Our cabins are not air conditioned and there is very limited air-conditioned space on the grounds. If the individual has temperature restrictions for 90 °and above, we will not be able to accept the camper.
- We cannot accept campers that require bed checks more than hourly. If the camper lives in a residence that requires bed checks more than every hour and it is not to address a specific concern, a Treatment Team Leader or Administrator must provide a letter that indicates hourly bed checks are acceptable while the individual is at camp.
- **We are unable to support campers that require a bed alarm, supplemental oxygen, open wounds, or those with or who receive nutrition via tube or other intense medical needs.**
- **Please complete ALL application fields, if not applicable please indicate such.**
- Send the application, postmarked by April 14th, to:
**Capitol District DDSO,
Camp Wilton,
3 Care Lane,
Saratoga Springs, NY 12866**

For more information:

Visit opwdd.ny.gov and search for "Camp Wilton" or Email: Camp.Wilton@opwdd.ny.gov

Camp Wilton 2023 Application

<input checked="" type="checkbox"/>	REQUIRED DOCUMENTS:
	\$275 CAMP FEE (NOTE. Camp Wilton is not a waiver funded program. Campers seeking to use self-direction funds to pay for camp must speak to their Care Manager to determine if these funds can be utilized.)
	LP LIFE PLAN (include narrative from most recent annual plan)
	SSP SAFEGUARD SUPPORT SUMMARY
	BSP: RISK MANAGEMENT OR BEHAVIOR PLAN
	CURRENT NURSING ASSESSMENT (For campers living in state or voluntary residences)
	CURRENT DIET ORDER
	CURRENT HISTORY and PHYSICAL EXAM (Exam within the last 12 months)
	SIGNED PARENT/GUARDIAN CONSENT FORM
	RECENT CLEAR PHOTO OF CAMPER (required for distribution of medication)
	DOCUMENTATION of ALL INOCULATIONS AND IMMUNIZATIONS
	MEDICATION LIST OR COMPLETED MAR
	CURRENT PHYSICIAN'S ORDERS

Please send all these documents with the fully completed camp application. Incomplete applications may result in a delay of a camper being accepted.

SESSION SCHEDULE

Session	Date	Details
1	June 19-23	Adults with Little or No need for Support
2	June 26-30	Adults with Moderate need for Support
3	July 3-7	Seniors Week
4	July 10-14	Adults with a High Need for Support
5	July 17-21	Adults with PWS
6	July 24-28	Adults with High need for Support
7	July 31-Aug 4	Adults with Moderate need for Support
8	August 7-11	Adults with Little or No need for Support

2023 CAMPER INFORMATION

CAMPER NAME: _____ Phone: () _____

SESSION NUMBER PREFERRED: 1 2 3 4 5 6 7 8

ADDRESS (street/city/state/zip): _____

Age: _____ Date of Birth: _____ Gender: M F X **T-Shirt size:** _____

CAMPER HEIGHT: _____ **CURRENT WEIGHT:** _____

How will the camp fee be paid? Check Money order PA Funds (Capitol DDSO only)

Camper Lives at: SOIRA VOCR VOIRA Family Care Home Independent Living

Catchment Area: (please check one of the following):

Capitol District Sunmount Valley Ridge Taconic Long Island

Central DDSO Staten Island Brooklyn Metro NY Finger Lakes

Western NY Bernard Fineson Hudson Valley Broome

Person completing the application:

Name: _____ Relationship to Camper: _____

Address (same as camper): _____

Phone Number (same as camper): () _____ Alt. Phone: () _____

Email: _____ Fax Number: () _____

Caregiver Name (if different from above): _____ Email: _____

Phone Number (if different from camper): () _____ Alt. Phone: () _____

Service Coordinator: _____ Email: _____

Phone Number: () _____ Alt. Phone: () _____

INSURANCE

A COPY OF THE CAMPER'S INSURANCE CARD WILL BE REQUIRED AT CHECK IN

Does this camper currently receive **MEDICAID**? YES NO

MEDICAID #: _____ TABS ID#: _____

Does this camper currently receive **MEDICARE**? YES NO

MEDICARE #: _____

Other insurance plan and number? _____

OPWDD Eligible? YES NO

Waiver Enrolled? YES NO

CAMPING EXPERIENCE

Is this the camper's first time attending Camp Wilton? YES NO Years of attendance: _____

Has the camper ever attended a different camp? YES NO Day Overnight

Did the camper enjoy the experience(s) and adjust well? YES NO Details: _____

What were the camper's favorite things about camp? _____

What were the camper's least favorite things about camp? _____

Does the camper have strong fears (e.g. darkness, water, thunder, bugs, animals, crowds)? YES NO

Details: _____

What methods should be used to address these fears? _____

How does the camper react when upset, homesick or frustrated? What methods should be used to address these behaviors? _____

Is there any further information not otherwise stated in this application that may be helpful in better understanding the camper and his/her needs at camp?

Does the camper require 1:1 supervision? YES NO Details: _____

What level of supervision does the camper need while in a camp or community environment (lots of people, open spaces)? _____

Is there any additional assistance the camper may require while at camp? _____

GENERAL MEDICAL INFORMATION

BRACES, SPLINTS & ADAPTIVE EQUIPMENT: please list, ***MUST BRING TO CAMP:***

COMMUNICATION (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Verbal and can be clearly understood by others | <input type="checkbox"/> Non-verbal |
| <input type="checkbox"/> Verbal but may be difficult to understand | <input type="checkbox"/> Gestures |
| <input type="checkbox"/> Uses communication board/device | <input type="checkbox"/> Uses sign language |
| <input type="checkbox"/> Other: _____ | |

ACTIVITIES OF DAILY LIVING

SLEEPING CONCERNS

In what position does the camper prefer to sleep during the night? _____

What assistance does this individual require for positioning during the night? _____

Equipment: Side rails Pillows Wedge Size of Wedge: _____

Level of supervision necessary while in this position: _____

Please note: Two staff members sleep in each cabin nightly and are responsible for routine bathroom trips and assistance. We cannot accommodate campers who require consistent and frequent assistance throughout the night. **We cannot accept campers who require bed checks more often than every hour or who require a bed alarm.**

Does the camper generally sleep well? Normal sleeping hours: _____ YES NO

Does the camper require bedrails, a bed alarm OR a special mattress? YES NO

Alarm, Rails or mattress type: _____

Is the camper capable of sleeping on a top bunk? YES NO

IF THE CAMPER'S RESIDENCE REQUIRES A 30 MINUTE BED CHECK, A WRITTEN APPROVAL FOR HOURLY CHECKS FROM THE TREATMENT TEAM LEADER MUST BE PROVIDED WITH APPLICATION.

Does the camper require more than hourly bed checks? YES NO

If the individual requires more than hourly checks, please indicate reason:

SELF-CARE

Activity	Independent	Verbal Reminders	Physical Assistance	Total Support	Details including adaptive equipment needed
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wears dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No Uses: <input type="checkbox"/> Toothbrush <input type="checkbox"/> Mouth Swabs/Toothettes <input type="checkbox"/> Mouth Wash
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toilet arms <input type="checkbox"/> YES <input type="checkbox"/> NO
Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses a shower chair? <input type="checkbox"/> YES <input type="checkbox"/> NO

How does the camper indicate they need to use the bathroom?

Is the camper incontinent at night? YES NO Details:

Is there a schedule for toileting? YES NO Schedule:

Activity	Independent	Verbal Reminders	Physical Assistance	Total Support	Details including adaptive equipment needed
Does the camper use the following? <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan <input type="checkbox"/> Commode					
Wears incontinence product (Attends)? <input type="checkbox"/> Night <input type="checkbox"/> Day <input type="checkbox"/> Not required					
Help with menstruation cycle? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA _____					
Help required: _____					
Comments/other: _____					

DINING

ATTACH A CURRENT DIET ORDER AND COMPLETE THE APPROPRIATE SECTION BELOW

FOOD CONSISTENCY

<input type="checkbox"/> Puree	Food is prepared using a food processor until smooth for an applesauce-like or pudding consistency.
<input type="checkbox"/> Ground	Food is prepared using a food processor until moist, cohesive and no larger than a grain of rice.
<input type="checkbox"/> ¼" Pieces Cut to Size	Food is cut with a knife or chopped in a food processor into ¼-inch pieces.
<input type="checkbox"/> ½" Pieces Cut to Size	Food is cut with a knife or chopped in a food processor into ½-inch pieces.
<input type="checkbox"/> 1" Pieces Cut to Size	Food is served as prepared and cut by staff into 1-inch pieces.
<input type="checkbox"/> Whole	Food is served as prepared, no changes in preparation or consistency.

BEVERAGE CONSISTENCY: if camper requires thickened beverages, they must bring thickener.

<input type="checkbox"/> Thin Liquid	Liquids are served without change.
<input type="checkbox"/> Nectar Thick Liquid	Thickened liquid that flows from the spoon in one steady stream; same consistency of the heavy syrup found in canned fruit, or maple syrup.
<input type="checkbox"/> Honey Thick Liquid	Thickened liquid that flows slowly from the spoon but still pours; same consistency of table honey in squeeze bottle containers.
<input type="checkbox"/> Pudding Thick Liquid	Thickened liquid that does not pour from the spoon; the spoon stands up in the product and requires a spoon for eating.

DIET SPECIFICATIONS

<input type="checkbox"/> Calories	_____
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Low Fat/Cholesterol <input type="checkbox"/> High Fiber <input type="checkbox"/> GERD <input type="checkbox"/> Gluten Free <input type="checkbox"/> Lactose Intolerant
<input type="checkbox"/> Other Diet Modification	_____
Nutrition Supplements & Frequency (nutritional drinks, puddings, powders, etc)	

<input type="checkbox"/> Fluid Restriction	_____
<input type="checkbox"/> Increased Fluids	_____

ADAPTIVE EQUIPMENT MUST BE BROUGHT TO CAMP

<input type="checkbox"/> High Need	Requires ongoing monitoring due to health concerns and swallowing requires specific training of techniques
<input type="checkbox"/> Consistent	Ranges from providing minimal prompts to needing direct assistance to dine.
<input type="checkbox"/> Supervised	May require assistance with set-up, cut-up and/or clean-up.
<input type="checkbox"/> Independent	Requires no supervision during dining/training protocol

FOOD PACING, PORTIONING & ADAPTIVE EQUIPMENT:

Portion Size:	<input type="checkbox"/> 1 spoonful	<input type="checkbox"/> 2-3 bites	<input type="checkbox"/> half of meal	<input type="checkbox"/> all of meal
Utensil:	<input type="checkbox"/> Regular	<input type="checkbox"/> Teflon-coated spoon	<input type="checkbox"/> Plastic spoon	<input type="checkbox"/> infant or small/fork spoon
	<input type="checkbox"/> Spoon/fork with built-up handle	<input type="checkbox"/> Curved spoon	<input type="checkbox"/> right	<input type="checkbox"/> left
	<input type="checkbox"/> Other: _____			
Dish:	<input type="checkbox"/> Regular	<input type="checkbox"/> High sided dish	<input type="checkbox"/> Scoop dish	<input type="checkbox"/> Inner lip plate
	<input type="checkbox"/> Dycem			

BEVERAGE SET-UP – PORTIONING/ADAPTIVE EQUIPMENT

Portion Size:	<input type="checkbox"/> Single Sip	<input type="checkbox"/> Multiple Sips	<input type="checkbox"/> Spoon Fed	<input type="checkbox"/> Other: _____
Cup:	<input type="checkbox"/> Cut-out cup	<input type="checkbox"/> Sippy cup	<input type="checkbox"/> Cup with built-in straw	<input type="checkbox"/> Handled mug
	<input type="checkbox"/> Regular	<input type="checkbox"/> with disposable straw	<input type="checkbox"/> no straw	Other: _____

DINING POSITION (Note the positioning for the individual and the dining assistant.)

<input type="checkbox"/> No special positioning needs for dining	<input type="checkbox"/> Needs armed chair
<input type="checkbox"/> Individual sits in a wheelchair at the table (specifications): _____	
<input type="checkbox"/> Dining assistant positioning: _____	
<input type="checkbox"/> Additional details: _____	

BEHAVIORAL PROFILE

So we can best prepare for and meet the needs of the camper, please provide accurate and detailed information as well as a current behavior plan, if available. Include behaviors displayed at home, at school/program and in the community.

Behavior	Never	Seldom	Often	Explain/Details
Enjoys social gatherings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Interacts with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Follows directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional outbreaks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physically aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PICA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Behavior	Never	Seldom	Often	Explain/Details
Scratches, hits or grabs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self-stimulating behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sensitive to touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses inappropriate language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wanders or runs away intentionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wanders unintentionally due to distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
What approaches are most effective to help camper de-escalate or calm?				
Are there any preferred activities?				

TRANSFERS/POSITIONING/MOBILITY

ATTACH A CURRENT MOBILITY FACT SHEET AND COMPLETE THE APPROPRIATE SECTION

AMBULATION – LEVEL OF ASSISTANCE

INDEPENDENT with all ambulation Walks with **DIRECT STAFF SUPPORT**
 Requires **ASSISTIVE DEVICE** for ambulation (cane, crutches, walker, etc.) Device: _____
 Comments: _____

WHEELCHAIR MOBILITY – LEVEL OF ASSISTANCE:

PLEASE NOTE: Many areas of camp have uneven surfaces or a distance between activities. If the camper uses a wheelchair for these situations, the chair and footrests should come with them to camp.

Type of wheelchair: Manual Power
 When? For long distances ONLY At all times
 Does the camper self-propel? YES NO

TRANSFERS: there are mechanical lifts available at camp

Independent Mechanical lift (with sling) Two-person lift One-person lift
 Stand-pivot transfer Sliding board transfer
 Alternative transfer (specify): _____
 Comments: _____

POSITIONING

Check all that apply.

- The individual is **Independent** with: In-wheelchair positioning Out-of-wheelchair positioning
 The individual is **Dependent** with: In-wheelchair positioning Out-of-wheelchair positioning

DAILY POSITIONING/RE-POSITIONING

What assistance does this individual require for positioning/repositioning during the day? _____

Frequency of out-of-chair repositioning: _____ Length of time: _____

Equipment: Floor mat Bed Wedge Pillows

Level of supervision necessary while in this position: _____

MEDICAL INFORMATION

THIS SECTION MUST BE FULLY COMPLETED FOR CAMPER TO BE ACCEPTED

Nursing is a critical component of camp operations. Please follow instructions as they are written. Failure to follow these instructions may result in the camper not being accepted or they may be sent home.

Camper Name: _____ DOB: _____

Home Phone: () _____ Alternate phone: () _____

Person to contact for Medical Consent

Name: _____ Relationship to Camper: _____

Phone Number: () _____ Alternate Phone Number: () _____

Alternate contacts in the event of an emergency, illness or injury

List individuals granted permission to pick up the camper at any time during the camper's session. Please inform the individual(s) prior to the camp session that they have been listed as a contact. Camp management will release the camper only to individuals listed below.

Name: _____ Relationship to Camper: _____

Phone Number: () _____ Alternate Phone Number: () _____

Name: _____ Relationship to Camper: _____

Phone Number: () _____

Alternate Phone Number: () _____ CODE Status _____

Primary Physician: _____ Phone Number: () _____
 Address: _____
 Surgeon (if applicable): _____ Phone Number: () _____
 Address: _____
 Specialist (if applicable) _____ Phone Number: () _____
 Address: _____

DIAGNOSIS (Please list)

IMMUNIZATIONS (Give dates of all inoculations AND attach a copy of the vaccination record.)

Hepatitis B Immune Positive Carrier Unvaccinated negative for carrier status

Has the camper had the **Hep B Vaccination Series**? Yes No

The Heptovax series does not mean they are immune. Attach a lab report that includes HepBSag, HepBSAb, HepBCoreAB **AND** Documentation of vaccination.

Tetanus: include documentation	Date of most recent Tetanus shot:
Varicella (Chicken Pox) <u>Disease or vaccination</u> (please circle choice)	Dates:
Immunization for COVID	Dates: 1 st _____ 2 nd _____ Booster _____ Manufacturer _____ Has camper had COVID? _____ Yes _____ No If so, when?

ALLERGIES

List all food, MEDICATION, and/or environmental allergies. Please note any severe reactions.			
Does the camper use an Epi-Pen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, why:
How are medications taken?	Whole <input type="checkbox"/>	Crushed <input type="checkbox"/>	Medications taken with: Liquids <input type="checkbox"/> Applesauce <input type="checkbox"/> Pudding <input type="checkbox"/> Other <input type="checkbox"/>
Does the camper require thickened liquids?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes indicate: Nectar <input type="checkbox"/> Honey <input type="checkbox"/> Pudding <input type="checkbox"/>
Lactose intolerant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Specify if taking lactaid or absorption aid _____

B.M. HISTORY:

If camper is independent with toileting, bowel movements are not tracked and they have no history of constipation, to ensure dignity, the camp nursing staff will not provide follow-up unless the camper complains of discomfort or presents discomfort with constipation.

Does the camper have issues with bowel movements or a history of constipation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, what medications are given for constipation: _____ on day # _____ of no B.M.
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DIABETES:

YES NO If yes, please respond below:

How is it controlled: Diet Oral Medication Insulin

What are the signs/symptoms when low? _____

What are the signs/symptoms when high? _____

Blood sugar testing? YES NO If yes, _____ times per day.

Method: Finger stick Continuous Glucose monitoring/ Patch
Libre/Dexcom

Is Low Blood sugar a frequent issue? Yes No

TEMPERATURE RESTRICTIONS? YES NO

If yes, please indicate what temperature below/above to limit outside activity: _____

SEIZURE ACTIVITY

Does the camper have a seizure disorder? YES NO

How often? Daily Weekly Monthly Controlled by medication

Date of last seizure: _____

Does the camper have any auras? Describe:

Describe type, duration, characteristics, known triggers, etc. _____

Does the camper use Vagus Nerve Stimulation (VNS)? YES NO

ASTHMA & OTHER RESPIRATORY ISSUES

Does the camper have asthma or respiratory issues?

YES **NO** If yes, please respond below:

Frequency of attacks? _____

Any activity limitations _____

Does the camper use oxygen?

YES NO

Do we need to check Oxygen saturation levels? YES NO

If yes, _____ times per day.

SLEEP APNEA

Does the camper have sleep apnea? YES NO If yes, please respond below:

Do they use C-Pap OR Bi-Pap machine? YES NO

If yes, please explain: _____

Any activity limitations? _____

This individual WILL NOT TAKE any routine medications while attending camp.

This individual WILL TAKE routine medications while attending camp.

CAMPER NAME: _____ Cabin # _____

MEDICATION ADMINISTRATION RECORD

Diet order changes: _____ Last BM: _____

Please note: if the camper requires thickened beverages, they must bring thickener.

A doctor's order is required for all prescription medications, over-the-counter medications and natural remedies, including topical treatments

Any medication that has been added or discontinued prior to arrival at camp must be accompanied by a written doctor's order or a copy of the prescription.

Campers should bring a **7-day** supply of medication. Medications not taken will be returned.

CODES H = HOSPITAL R = REFUSED		ALLERGIES:	MONTH/YEAR:					
			Dates					
Camp Staff Only #Pills	Bottle #	Medication, Pills, Liquids, Drops, Powders, other	TIME	M	T	W	T	F
		Med: _____ Dose: _____						
		Med: _____ Dose: _____						
		Med: _____ Dose: _____						
		Med: _____ Dose: _____						
		Med: _____ Dose: _____						

CAMPER NAME: _____

DOB: _____

ALLERGIES: _____

STANDING ORDERS

NOTE!! A REGISTERED NURSE MUST BE CONTACTED PRIOR TO ADMINISTERING ANY OF THE FOLLOWING MEDICATIONS:

(EXCEPTION: 1st dose of ACETAMINOPHEN for fever or a behavior PRN per Behavior Support Plan. Staff must call RN AFTER giving.)

(For fever--Physician is to be contacted if fever persists beyond 24 hours from onset.)

ACETAMINOPHEN (e.g. Tylenol) _____ mg PO or PT or PR (suppository) every 4 hours as needed for: Oral/Tympanic/ Temporal temperature above 100.5 degrees F, or rectal temperature above 101 degrees F, or for signs / symptoms of general discomfort / e.g. headache, toothache, muscle pain. **(MDD = 4 doses in 24 hours)**

ALUMINUM / MAGNESIUM (HYDROXIDE) w / SIMETHICONE (e.g. Regular Strength Mylanta or Maalox Plus) 30 ml PO or PT every 6 hours as needed forminor stomach upset or indigestion. **(MDD 4 doses in 24 hours)**

GUAIFENESIN w / DEXTROMETHOPHAN (e.g. Regular Strength Robitussin DM) 10ml PO or PT / every 4 hours for minor cough without fever. **(MDD = 6 doses in 24 hours)**

MAGNESIUM HYDROXIDE IN WATER (e.g. Phillips Milk of Magnesia) 30 ml PO or PT for no bowel movement in 72 hours. Drink a full glass (8 oz.) of liquid with each dose. **(MDD = one dose in 24 hours)**
NOTE! DO NOT USE IF SYMPTOMS OF ABDOMINAL PAIN, RECTAL BLEEDING, NAUSEA OR VOMITING ARE NOTED OR IF SPECIFIC BOWEL REGIME IS ALREADY IN PLACE, WITHOUT FIRST CONSULTING A REGISTERED NURSE.

BISACODYL (SUPPOSITORY) (e.g. Dulcolax) (use only if MOM ineffective after 24 hours) 10 mg PR (suppository) **(MDD = one dose in 24 hours).**
NOTE! DO NOT USE IF SYMPTOMS OF ABDOMINAL PAIN, RECTAL BLEEDING, NAUSEA OR VOMITING ARE NOTED OR IF SPECIFIC BOWEL REGIME IS ALREADY IN PLACE, WITHOUT FIRST CONSULTING A REGISTERED NURSE.

ZINC OXIDE TOPICAL CREAM (e.g. Desitin) **Apply** liberally and as necessary to clean dry skin to prevent /treat moisture rash.

BACITRACIN ANTIBIOTIC OINTMENT: Clean affected area with soap and water, then dry. Apply topically TID / PRN for superficial abrasions.

NEW SKIN LIQUID BANDAGE SPRAY: Clean affected area with soap and water, then dry.

INSECT REPELLENT Apply to both exposed skin and clothing prior to outdoor activity. Repeat after 8 hours as needed (early spring thru late fall). **(MDD= 2 applications in a 24-hour period).**

SUNBLOCK Apply (UVA/UVB) sunscreen with SPF 45 or higher topically to exposed skin 30 minutes prior to sun exposure. Reapply every 2 hours throughout the day for continuous sun exposure, after swimming, excessive sweating and/or toweling.

HOLD STOOL SOFTENERS AND / OR LAXATIVES X 48 HOURS FOR LOOSE STOOLS. Notify nurse or physician. Examples: Colace, Peri-Colace, Senokot, Senakot-S, Dulcolax, MOM, Citrate of Mag., Glycolax, Miralax, Sorbitol, Amitiza)

MEDICAL CLEARANCE: Individual is cleared to swim with supervision.

LOPERAMIDE HYDROCHLORIDE (e.g. Imodium A-D) 4 mg PO or PT initially, followed by 2 mg PO or PT after each subsequent loose stool. **(MDD = 16 mg in 24 hours).**

DIPHENHYDRAMINE (e.g. Benadryl) 25 mg, PO or PT every 6 hours for temporary relief from symptoms due to hay fever or other upper respiratory (allergies e.g. itchy watery eyes itching of the nose or throat. May also be used for environmental rashes, insect bites, or minor rashes caused by certain foods. **MDD = 4 doses in 24 hours)**

PSEUDOEPHEDRINE (e.g. Sudafed) 60 mg PO or PT every 6 hours as needed for nasal congestion. **(MDD = 4 doses in 24 hours)**

Physician's Signature _____

DATE: (Standing order valid for one year from above date) _____

CAMPER NAME: _____

CAMP WILTON CONSENT

CONSENT TO TREAT

In the event of an emergency wherein any of the documented physicians are not available, I give my consent to provide treatment and to conduct any tests by appropriate medical staff on duty that are required to intervene and obtain necessary medical care.

CONSENT TO ATTEND AND PARTICIPATE

I hereby request and give permission to the New York State Office for Developmental Disabilities permission for the named camper to attend Camp Wilton and participate in all activities. I also agree not to send this individual to Camp if exposed to a contagious disease within 21 days of the date the applicant is to report to Camp, and I will notify the Camp Director immediately.

MEDICATION AUTHORIZATION (check one)

NO The below named camper does not need to take any routine medication (prescription or over-the-counter) while at camp.

YES The below named camper will need to take medication while at camp. I authorize administration of the prescribed medications.

PERMISSION TO APPLY SUNSCREEN AND BUG SPRAY

I give the staff at Camp Wilton permission to apply the following to the below named camper.

Sunscreen

Bug Repellent

PHOTO RELEASE (check one)

Permission is given to Camp Wilton and OPWDD to use any photograph, digital or video taping of the camper and the camper's name for television news stories, newspaper articles, news releases, publications (brochures, newsletters, website, etc.) and community awareness programs.

Permission is not given

WAIVER

All the information provided is accurate and complete to the best of my knowledge.

As the Parent/Guardian/Advocate of _____, I have read and understand the above.
Camper Name

Parent/Guardian/Advocate Signature

Date

Relationship to camper

CAMPER NAME: _____

SWIMMING INFORMATION

Swim assessments will be done at camp by our Red Cross certified life guards. Assessments will be sent home with the camper at the end of the session.

Does the camper enjoy swimming? YES NO

Will the camper swim at camp? YES NO

If the camper does not enjoy swimming, will they want to be at the pool during swim time?

YES NO

Will the camper enjoy dipping their feet in the water? YES NO

Does the camper wear ear plugs when in the pool? YES NO

Are there any swimming restrictions? YES NO Details: _____

As the Parent/Guardian/Advocate of _____, I have read and understand the above.
Camper Name

Parent/Guardian/Advocate Signature

Date