



CAMP EXPLORER
HEALTH STATEMENT



At the time of admission, information regarding all immunizations a child has had, including month and year each immunization was administered, must be provided to Camp Explorer. Immunizations must be recorded on the Certificate of Immunization or alternate **approved immunization form supplied and approved by the Colorado Department of Public Health and Environment (CDPHE)** and kept on file at the center.

Child's Name: _____ Sex: _____ D.O.B. _____

Physician's Name: _____

Address: _____ Phone: _____

Allergies: _____

Surgery/Accidents/Illnesses/Chronic Health Problems: _____

Is the child on any medications? (explain) _____

Physical limitations _____ Describe _____

Dietary limitations _____ Describe _____

Vision _____ Hearing _____

I will not allow my camper to attend if he/she becomes exposed to any contagious disease or if, for any reason, I do not consider my child to be in good physical condition.

Signature of parent or guardian

Date

DAY CAMP EMERGENCY CARD 2012

Child's Name: _____

Home Phone Number: _____

Date of Birth: _____

Home Address: _____

Hair Color: _____ Eye Color: _____

Mother's Name: _____

Phone # _____ (If different than above)

Place of Employment: _____

Address _____ Phone Number _____

Father's Name: _____

Phone # _____ (If different than above)

Place of Employment: _____

Address _____ Phone Number _____



Child's Doctor: _____

Phone # _____

Child's Dentist: _____

Phone # _____

Hospital of Choice: _____

Emergency contact to call if parent can not be reached and medical authorization may be obtained:

Name: _____

Phone # _____

Address: _____

Relationship: _____

Name: _____

Phone # _____

Address: _____

Relationship: _____

Name: _____

Phone # _____

Address: _____

Relationship: _____

PERSON'S AUTHORIZED TO PICK UP CHILD
 (include yourself):

1. Name/Phone # _____

2. Name/Phone # _____

3. Name/Phone # _____

4. Name/Phone # _____

5. Name/Phone # _____

Any Allergies or Health Problems we need to be aware of: _____

Special Instructions: _____

Medications: _____

Emergency Medical Authorizations:

I, _____, Hereby give my permission to the City of Broomfield Staff to call a doctor for medical or surgical care for my child,

_____ , should an emergency situation arise. It is understood that a conscious effort will be made to locate me or my spouse before any action will be taken, but if it is not possible to locate us, this expense will be accepted by us.

Signature of Parent or Legal Guardian _____

Date _____



CAMP EXPLORER INFORMATION SHEET

Child's Full Name: _____ Nickname: _____

Sex: _____ Age _____ Date of Birth _____ Date of Enrollment _____

Child's Home Address _____

Mother/Guardian Name: _____ Phone # _____

Home Address (if different) _____

Employment Name & Address: _____

Employment Phone # _____

Cell #/Pager _____ Fax _____ Email _____

Father/Guardian Name: _____ Phone # _____

Home Address (if different) _____

Employment Name & Address: _____

Employment Phone # _____

Cell #/Pager _____ Fax _____ Email _____

Any Special Instructions how to be contacted during operating hours: _____

Name of Child's Physician: _____ Phone # _____

Address of Physician: _____

Name of Child's Dentist: _____ Phone # _____

Address of Dentist: _____

Name/Address of Preferred Hospital: _____

Person to contact when parents cannot be reached: _____

Home Phone _____ Work Phone _____

Address _____



**CAMP EXPLORER
PERMISSION SIGNATURES**

Child's Name: _____
Please Print

Parent's Name: _____
Please Print

G/PG Movies:

I give my permission for my child to watch G/PG movies during the summer program.

Parent Signature

Walks:

I will allow my child to participate in supervised walks within one mile area surrounding the Day Camp Site.

Parent Signature

Sunscreen:

I hereby grant the City and County of Broomfield Recreation Services Department permission to apply sunscreen to my child. I agree to apply sunscreen to my child before dropping him/her off at camp. I will supply my child with a spray sunscreen and sun stick each day at camp and I understand if my child does not have sunscreen with them they will not be allowed to participate in outdoor activities or will be required to stay in the shade. I will provide written notice if a child has already applied sunscreen themselves and do not wish to have my child re-apply.

Parent Signature

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby give my permission for City & County of Broomfield staff to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child should an emergency arise. It is understood that the City & County of Broomfield day camp staff will make a conscientious effort to locate the parent/guardian or the emergency contact listed on the registration document before any action will be taken. If it is not possible to locate the emergency contact listed, I will accept the expense of emergency medical or surgical treatment.

Parent's Signature

Date



**CAMP EXPLORER
SUPERVISION STATEMENT FOR CRESTONE/EXTREME
CAMPERS**



Child's Name _____

This letter is to give (or not give) your permission for your child(ren) to explore field trips without an adult. **This form is only for campers entering 5th grade or higher (Camp groups Crestone and Extreme)** and for the following field trips: The Bay, Heritage Square, Pirate's Cove, Fun City, Argo Mine, Boondocks, Adventure Golf, Skate City, Brighton Oasis, and Casa Bonita.

This form will not apply to the following field trips: Paul Derda Recreation Center, Elitch Gardens, Washington Park, Water World, The Reservoir, Rafting, and Mid-Air Adventures and all campers will be required to be in groups unless signed out.

_____ YES I will allow my child to walk around in groups without a staff member. The campers need to be in groups of 3 or more and will be given meeting points approximately every 2 hours to check in and re-group. Camp Explorer Staff will still be present the entire day and responsible for a group of children in a ratio of 1:15 or less.

_____ NO I will not allow my child to walk around in groups without a staff member. Please have a staff member present with my child.

Parent Signature

Date



CLIMBING WALL

*****DAY CAMPS ONLY 2012*****

This waiver will not be valid for any other time. If the climber stated in this waiver wishes to climb at the Paul Derda Recreation Center out side of this summer camp, a new waiver will need to be on file.

**The City and County of Broomfield Recreation Services
Climbing Wall**

ACKNOWLEDGEMENT OF RISK, WAIVER AND RELEASE

In consideration of being permitted to take part in the activity, or utilize the climbing wall as set forth here in, I expressly agree as follows: I hereby acknowledge that climbing and bouldering contains dangers and risks and may result in injury to the participant. I hereby assume all risks of personal injury, death, and property damage from any causes what so ever arising while my child or I are participating in such activity. I, or my child, are in good health and are physically able to participate in any and all climbing activities. I agree to unconditionally waive and release the City and County of Broomfield and it's officers. employees, volunteers, agents , servants , and all representatives and sponsors from any and all injuries, claims, causes of action and liabilities of any nature and kinds that I or my child may sustain, or any damage that may be caused to my or my child's property in connection with said activities or use of such facilities or services , including injuries sustained or property damage caused by any use of equipment I may rent or borrow from the City and County of Broomfield Recreation Services, their officers ,employees , agents , servants or sponsors, to the extent allowed by law.

I understand that the Climbing Wall is 35 feet high, ranging from beginning to advanced degrees of difficulty, including overhangs, cracks, and hand holds. I hereby acknowledge and agree that the activity of rock climbing and the use of the Paul Derda Recreation Center Climbing Wall has inherent risks. I have full knowledge of the nature and extent of all the risks associated with rock climbing and the use of the wall, including but not limited to:

1. All manner of injury resulting from falling off the climbing wall and hitting holds, faces and projections, whether permanently or temporarily in place, or the floor;
2. Rope abrasion, entanglement and other injuries resulting from activities on or near the climbing wall such as, but not limited to, climbing, belaying, rappelling, lowering on rope, rescue systems, and any other rope techniques;
3. Injuries resulting from falling climbers or dropped items; such as, but not limited to, ropes or climbing hardware;
4. Cuts and abrasions resulting from skin contact with the climbing wall;
5. Failure of equipment, whether issued by Broomfield Recreation Services or of my own property, including but not limited to ropes, slings, harnesses, climbing hardware, anchor points, or any part of the climbing wall structure;
6. Muscle strain, contusions and rope burns caused by belaying another climber.

I further realize that not all risks are listed herein and acknowledge that I am voluntarily and willingly participating in this activity even though some risks are apparent and others are not identifiable.

Any Paul Derda Recreation Center staff may require a climber or belayer to re-take the Safety Test or Belay Test if there is any reason to believe that the climber's capabilities have degraded, are impaired, or are suspect.

I also authorize and consent to any emergency X-ray examination, medical diagnosis, or treatment or hospital care to be rendered to me or my child under the general or special supervision, and on the advice of any physician licensed to practice in the State of Colorado.

Participants may be photographed while utilizing the facility, services, or participating in a Broomfield Recreation Services program and said photographs, or likeness of me, may be used to publicize activities as the City and County deem appropriate.

Please print and fill out this form COMPLETELY in INK

Climber'sName _____ BirthDate _____

Address _____ Apt. # _____

City _____ Zip _____

Email _____

Home Phone _____ Work Phone _____

Emergency Contact _____ Emergency Phone _____

Signature _____ Date _____

(participant or guardian if participant is under 18 years of age)



CAMP EXPLORER
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION



OPTIONAL FORM

The parent/guardian of _____ ask that child care staff
(child's name)
give the following medication _____ at _____
(Name of medication and dosage) (Time(s))
to my child, according to the Health Care Provider's signed instructions and the lower
part of this form.

Camp Explorer agrees to administer medication prescribed by a licensed health care
provider. It is the parent/guardian's responsibility to furnish the medication. The parent
agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of
medicine, time medicine is to be given, dosage, date medicine is to be stopped, and
licensed health care provider's name. Pharmacy name and phone number must also
be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match
the signed health care provider authorization, and medicine must be packaged in
original container.

By signing this document, I give permission for my child's health care provider to share
information about the administration of this medication with the camp staff delegated to
administer medication.

Parent/Legal Guardian Name Parent/Legal Guardian Signature Date

Work Phone Home Phone

Health Care Provider Authorization to Administer Medication at Day Camp
Child's Name Birth Date:
Medication
Dosage Route:
To be given at the following time(s):
Special Instructions
Purpose of Medication
Side effects that need to be reported
Starting Date: Ending Date:
Signature of Health Care Provider with Prescriptive Authority (must include credentials) License Number
Phone Number Date

Please ask the pharmacist for a separate medication bottle to keep at camp. Thank you!



**CAMP EXPLORER
AUTHORIZATION FOR EPI-PEN**



OPTIONAL FORM: Severe Allergy to: _____

Camper Name: _____ Birth Date: _____

Emergency Treatment

If child experiences mild symptoms: *Several hives, itchy skin, itchy watery eyes, or nasal symptoms* **OR** if an ingestion is suspected:

Treatment.

1. Send camper to director ACCOMPANIED.
2. Give _____ of _____ by mouth.
(amount and dosage) (antihistamine)
3. Contact the parent or emergency contact person.
4. If exposed—Have child wash face, hands, and exposed area.
5. Stay with the camper; keep camper quiet, monitor symptoms, until parent arrives.

Watch child for more serious symptoms listed below.

Special Instructions:

Symptoms that progress and can cause a life threatening reaction:

- Hives
- Wheezing, difficulty swallowing/breathing, swelling (face, neck), tingling/swelling of tongue.
- Vomiting
- Signs of shock (extreme paleness/gray color, clammy skin, etc.), loss of consciousness

Treatment:

1. Give: Epi-Pen Jr. (under 66 lbs) OR Epi-pen (66 lbs & over) immediately
Place against upper outer thigh, through clothing if necessary.
2. Call 911 immediately
3. Epi-pen only lasts 20-30 minutes **Paramedics should always be called if Epi-Pen is given**
4. Contact parents or emergency contact person. If parents unavailable, staff should accompany child to the hospital.

Directions for use of Epi-Pen:

1. Pull of gray cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, and then remove.
5. Discard Epi-Pen in impermeable holder using one hand or can and dispose per policy, or give to emergency care responder.
 - If Symptoms don't improve after _____ minutes, administer second dose following steps 1-5.

It is understood by parents and health care provider(s) that this plan may be carried out by camp personnel other than the Nurse consultant (RN). A RN is responsible for delegation of this Health Care Plan to unlicensed persons.

Health Care Provider Authorization: (with credentials, required) _____ Date: _____

Parent/Guardian Signature (Required): _____ Date: _____

Camper Name: _____ Birth Date: _____

Allergies (food, insects, medication, etc):	Reaction:
_____	_____
_____	_____
_____	_____
Diet Restrictions: For food allergies: <input type="checkbox"/> parents will monitor lunch and provide food and communicate with camp personnel <input type="checkbox"/> Camper will self-monitor food choices <input type="checkbox"/> Other: _____	
Medication used on a daily basis (Include doses): HOME: _____ CAMP: _____ Reminder: Camp personnel must take Epi-Pen or any other medications on all field trips. Make sure phone is close by, if needed. Keep Epi-Pen at room temperature. DO NOT FREEZE, refrigerate, or keep in extreme heat.	
Health Care Provider who should be called regarding the allergic reaction: Name: _____ Phone: _____ Hospital Preference: _____	

If _____ experiences a change in health condition (such as a change in medication or hospitalization) please contact the Camp Director so that this Health Care plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I also understand that this information may be shared with necessary camp personnel on a need-to-know basis to help ensure this child's safety and well being while at camp.

Parent/Guardian signature: (Required) _____ Date: _____

Health Care Provider Authorization: (with credentials, required) _____ Date: _____

Administrator Signature: (Preferred) _____ Date: _____



**AUTHORIZATION FOR NEBULIZER TREATMENTS OR
INHALED MEDICATION
OPTIONAL FORM**

The parent/guardian of _____ ask that child care staff
(child's name)
give the following medication _____ at _____
(Name of medication and dosage) (Time(s))

to my child, according to the Health Care Provider's signed instructions and the lower part of this form. Camp Explorer agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication and equipment and to keep daily emergency contact information up to date.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the camp staff delegated to administer medication.

Parent/Legal Guardian Name Parent/Legal Guardian Signature Date

Work Phone Home Phone

Health Care Provider Authorization	
Child's Name _____ Birth date: _____	
Name of Inhaled Medication _____	
Dosage _____ Why given (circle): wheezing, coughing, shortness of breath, difficult breathing.	
To be given at the following time(s): _____ may be repeated every _____ hours.	
Note to health care provider: Specific time and/or interval must be indicated on this form in order for non-medical persons in center to administer medication.	
Start Date: _____ End Date: _____	
Usual (baseline) respiratory rate for this child: _____	
Comments: _____	
Seek Emergency Medical Care if the child has any of the following:	
<input type="checkbox"/> Respiratory rate greater than: _____ <input type="checkbox"/> Coughs constantly <input type="checkbox"/> Hard time breathing with <input type="checkbox"/> Chest and neck pulled in with each breath <input type="checkbox"/> Struggling or gasping for breath <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Lips or fingernails are grey or blue <input type="checkbox"/> Other: _____ <input type="checkbox"/>	
_____ Signature of Health Care Provider with Prescriptive Authority (must include credentials)	
_____ Physicians Phone Number Fax	



**CAMP EXPLORER
OPTIONAL FORM**



Child Name: _____ Birth Date: _____

When I enrolled my child at your center, I informed you that my child does have the following medical condition: _____.

However, at this time I do not wish to supply you with any medication for the above-mentioned condition and do take full responsibility for any reactions or problems related to my child's medical condition while in your care. I acknowledge that I have been informed that if any emergency situation occurs, 911 will be called to provide care for my child.

I have also reviewed this with the child's medical care provider and their signature is below to concur with my decision in regards to my child's medical condition.

Sincerely,

(Parent/Guardian Signature)

Date: _____

(Parent/Guardian Printed Name)

(Health Care Provider Signature)

Date: _____

(Health Care Provider Printed Name)