NEW YORK STATE DEPARTMENT OF ENVIRONMENTAL CONSERVATION

Division of Communication, Education, and Engagement, Bureau of Environmental Education
625 Broadway, 3rd Floor, Albany, New York 12233-4501
P: (518) 402-8043 | F: (518) 402-9033
www.dec.ny.gov

IMPORTANT NEED TO READ

February 2024

Dear Parent/Guardian of a DEC Camper,

This letter contains important information about DEC's procedures regarding administrating medications to campers. Please read it thoroughly to help your check-in at summer camp go smoothly.

New for 2024, there is one Health Care Provider form for DEC Summer Camps. The same form will be used no matter which camp your child attends. Please note, DEC will not accept a generic form from your doctor's office.

For parents of campers at Camp DeBruce, Rushford and Pack Forest: Before arriving at check-in, make sure you have written approval with you from your health care provider for any prescribed and over-the-counter (OTC) medications you bring for your camper(s) to take on a scheduled basis throughout the week. **Written approval that says only "as needed" or "pro re nata (PRN)" will NOT be accepted.**

Due to a shortage of registered nurses, DEC employs emergency medical technicians (EMTs) as health directors at our summer camps. Although these professionals are well trained in first responder techniques and procedures, the New York State Department of Health (DOH) limits what they are authorized to do.

The DOH notified DEC that we may not be able to offer "as needed" or OTC medications at our camps because our health directors are EMTs. Consequently, no "as needed" or OTC medications such as Ibuprofen, acetaminophen, antacids, and antihistamines, topical antibiotics will be available to our campers. The only time campers will have access to these types of medications will be through scheduled dosing previously approved in writing by a licensed health care provider, or through a visit to an urgent care facility or hospital. If your child needs any OTC medication you will need to have your health care provider write a prescription stating dosage and schedule; this CANNOT be written "AS NEEDED" or "PRN". Without this written prescription from your health care provider camp staff will need to drive your child to an urgent care facility or hospital for any over-the-counter medication.

To better serve campers, DEC contacted medical professionals in communities near each camp to request assistance with the administering medications, but the response has been mixed. The hospital in Saranac Lake will have a registered nurse (RN) visit Camp Colby during the summer to oversee administering medications. Unfortunately, DEC has *not* received any positive responses from the medical communities near Camp DeBruce, Rushford and Pack Forest.

If you have any questions regarding the Health Care Provider Form or the camp program, please call DEC at 518-402-8014 Monday through Friday from 9:00 AM until 4:00 PM, or email us at educationcamps@dec.ny.gov.

Sincerely,

Jackson Patterson
NYSDEC Environmental Educator 3/ Camps Administrator

NEW YORK STATE | Department of Environmental Conservation

DEC ENVIRONMENTAL EDUCATION SUMMER CAMPS

Bunk #_____

HEALTH CARE PROVIDER FORM - Scan and upload or bring form with you to camp check-in

MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER *and signed by*

LICENSED HEALTH CARE PROVIDER and PARENT

This health form is for a one week session of camp - less than 7 consecutive nights.

Camper's Name: _____ Date Of Birth: _____

HEALTH CARE RECOMMENDATIONS BY LICENSED HEALTH CARE PROVIDER

NEW YORK STATE | Department of Environmental Conservation

I examined this individual on _____.

BP _____ Weight _____ Height _____

In my opinion, the above camper/staff: ❑ is ❑ is not able to participate in an active camp program.

The camper/staff is under the care of a physician for the following conditions: _____

_____

Any medically-prescribed meal plan or dietary restrictions: _____

_____

Known allergies to medication, food or other (insect stings, hay fever, asthma, animals, etc.): _____

_____

Description of any limitation or restriction on camp activities: _____

_____

Additional information for health care staff at the camp about the camper/staff: _____

_____

Has the camper been taken off any medication for the summer? ❑ Yes ❑ No

If yes, does this medication have an effect on the camper's behavior? _____

_____

IMMUNIZATION HISTORY (Print out of camper's vaccination record is acceptable for this section only) It should be stapled to this form:

Has the camper had any of the following, listed below?

- ❑ Measles
- ❑ Chicken Pox
- ❑ German Measles
- ❑ Mumps
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C

Please give all dates of immunization for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus Influenza B	_____	_____	_____	_____		
Hepatitis B		_____	_____	_____		
Varicella (Chicken Pox)	_____	_____				
Meningoccal Meningitis	_____	_____				
COVID-19	_____	_____	_____	_____	_____	_____

Date of last TB Mantoux Test: _____ Result: ❑ Positive ❑ Negative

STANDING INDIVIDUALIZED ORDERS FOR:

Camper's Name: _____

PHYSICIAN - PLEASE NOTE THAT HEALTH DIRECTORS ARE EMERGENCY MEDICAL TECHNICIANS.
E.M.T.'S cannot do diagnostic procedures and distribute 'AS NEEDED' medication. All Medications must be scheduled.

Prescription Medications: Please complete with patient's current regimen for scheduled medications. All medications must be in original prescription/ Over-The-Counter (OTC) medication container. All OTCs must be prescribed by a Health Care Provider with exact time, schedule and dose. Medications will be self administered and witnessed by the Camp EMT. Self-carry medication release for epi-pens, insulin pumps, and Albuterol, Proventil and other rescue inhalers require a health care provider written order and listed in the below chart.

Drug Name	Route	Dosage	Schedule and Indications	Comments
sample medication	by mouth	X MG	everymeal and bed time	may refuse

Health Care Provider Please add additional pages if needed.

Standard Over-the-Counter Medications: The Emergency Medical Technician (EMT) who is the Health Director shall not assess the health condition of any camper in order to administer standard over-the-counter medications to campers. The EMT shall not administer standard over-the-counter medications to campers. We have arranged for a Registered Nurse to visit the camp for a short period each day on Monday - Thursday to dispense as needed medications. The Health Care Povider must complete the below information for the nurse to administer any AS NEEDED medication during her visit. **Failure to complete this section shall constitute non-authorization and the standard over-the-counter medications may not be given to the camper.** Completion of this section is not required. These are "AS NEEDED" or "PRN".

Drug	Route	May refuse	Schedule and Indications	Camper Healthcare Provider Order
Benadryl	By mouth (elixir, chewable tabs or pills)	❑Yes ❑No	Q 6 hr for allergic reaction, hives, insecct bites	❑Yes ❑No
Claritin 10mg	By mouth	❑Yes ❑No	Daily for allergy symptoms as per label	❑Yes ❑No
Zyrtec 10mg	By mouth	❑Yes ❑No	Daily for allergy symptoms as per label	❑Yes ❑No
Maalox 10 cc	By mouth	❑Yes ❑No	For stomach upset as per label	❑Yes ❑No
Acetaminophen	By mouth	❑Yes ❑No	as per label	❑Yes ❑No
Ibuprofen	By mouth	❑Yes ❑No	as per label	❑Yes ❑No
OTC Cough drops	By mouth	❑Yes ❑No	for cough, as per label	❑Yes ❑No
Tums. Rolaids	By mouth	❑Yes ❑No	For upset stomach as per label	❑Yes ❑No
Pepto Bismol	By mouth	❑Yes ❑No	For upset stomach as per label	❑Yes ❑No
Hydrocortisone	Apply topically	❑Yes ❑No	Q 4 hr for itch as per label	❑Yes ❑No
Calamine Lotion	Apply topically	❑Yes ❑No	Q 4 hr for itch	❑Yes ❑No
Neosporin	Apply topically	❑Yes ❑No	as per label	❑Yes ❑No
Bacitracin 1%	Apply topically	❑Yes ❑No	as per label	❑Yes ❑No

HEALTH CARE PROVIDER AUTHORIZATIONS

Camper's Health Care Provider Name: _____
Address: _____ **Phone:** _____

Health Care provider Signature: _____ **License #:** _____

Date: _____ **Fax:** _____

Parent Signature: _____ **Date:**_____ **Phone:**_____

***For Camp Use Only ***
Camper Name (last, first, MI): _____
Cabin or Group: _____
Camper Bunk #: _____