PARTICIPANT NAME:_____

COLORADO SUMMER CAMP ADDITIONAL REQUIRED INFORMATION

Colorado Addendum – Additional Information

This information is required by the State of Colorado Department of Human Services, Division of Early Learning and Care, Office of Child Care Licensing. Comments about this additional paperwork can be directed to the State of Colorado Department of Human Services, Office of Early Childhood at 303-866-5948 or cdhs_oec_communications@state.co.us.

ALL INFORMATION MUST BE FILLED OUT ENTIRELY

Specific dates you child is attending camp. *(Child Care Regulation 7.711.41.A.5)*	Dates:
Please list the contact information for the parent or legal guardian. *(Child Care Regulation 7.711.411.A.2)*	Name: _____ Relationship: _____ Home Address: _____ _____ _____ Work Address: _____ _____ _____ Phone Number: _____ Email Address: _____
Authorized Person(s) allowed to take the child from camp if the parent or guardian is unavailable. *(Consider listing the **adult leaders doing transportation to and from camp**, and another emergency contact. Attach additional sheets as needed. Unless someone is listed, the parent/guardian must pick up the child from camp.)* *(Child Care Regulation 7.711.411.A.4)*	Name: _____ Relationship: _____ Phone Number: _____ Address: _____ _____ Name: _____ Relationship: _____ Phone Number: _____ Address: _____ _____
Sunscreen Authorization *(Child Care Regulation 7.711.31.O)*	I, (print parent/guardian name) **DO** or **DO NOT** (circle one) authorize my child to use and wear sunscreen at camp. I also authorize BSA Health Staff to aid my child in the application of sunscreen if they request it at the camp's health lodge. I understand that if my child needs sunscreen, they can request it at the camp health lodge and it will be a SPF 30 or greater. **I also understand that my child's name needs to be written on the sunscreen bottle they come to camp with.** Signature: _____

COLORADO SUMMER CAMP ADDITIONAL REQUIRED INFORMATION

Colorado Addendum – Contract to Carry

This is for Scouts (Youth - 17 & younger) who need to carry emergency medications while at summer camp.

ALL SIGNATURES ARE REQUIRED

This contract is intended for Scouts diagnosed with asthma, anaphylaxis, severe allergies, and/or other life-threatening conditions and is in effect while the Scout is at camp. Colorado Child Care Regulation 7.711.31.4.

Scout Name: _____ Date of Birth: _____

Camp: _____ Medication(s): _____

Purpose of Medication(s): _____

Scout/Child:

- I agree to keep my medication with me while at camp and use it in a responsible manner.
- I will notify Camp staff when I use my medication.
- I will notify Camp Health Staff immediately if my condition for which I am prescribed my medication presents any unusual difficulty or symptoms.
- I will not allow any other Scout to administer or use my medication.
- I understand that if I fail to comply with this contract, my privilege to carry and self-administer the medication may be withdrawn, which could result in being sent home from camp.

Scout Signature: _____ Date: _____

Parent or Guardian:

- I assure that my child will carry his/her medication as prescribed, that the medication will be appropriately labeled by a pharmacist or healthcare provider and that the medication has not expired.
- I will assure that back-up medication is provided to the Camp Health Staff for emergencies.

Parent/Guardian Signature: _____ Date: _____

Unit Leader:

- I agree to make sure the Scout will keep the medication with them at all time and make sure that it is used in a responsible manner.
- I will monitor the Scouts use of the medication and alert the Camp Health Staff if the medication is used and if the Scout's condition gets worse or do not resolve in a timely manner.
- I will monitor the medication and ensure that it will not be administered or used by another Scout.
- I have reviewed the medical condition for which the Scout is provided the medication for.

Unit Leader Signature: _____ Date: _____

Doctor or Health Care Provider:

- I assure that the child listed on this document needs the listed medications and can self-administer as needed.
- I assure that the child is aware of the proper procedure of self-administering.

Health Care Provider Signature: _____ Date: _____

Camp Health Staff:

- I assure that the child has demonstrated the proper technique for self-administering the medication.
- I assure the child knows the proper times and dosages for when to administer.
- I assure that the appropriate Camp Staff will be notified of the child's condition and that they are carrying medication.

Health Staff Signature: _____ Date: _____

This information is required by the State of Colorado Department of Human Services, Division of Early Learning and Care, Office of Child Care Licensing. Questions about this additional paperwork can be directed to the State of Colorado Department of Human Services, Office of Early Childhood at 303-866-5948 or cdhs_oec_communications@state.co.us.

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: ..... **Date of birth:** .....

Parent/guardian: .....

Required vaccines

Immunization date(s) MM/DD/YY

Titer date* MM/DD/YY

Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** – positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

Immunization date(s) MM/DD/YY

HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: ..... Date: .....

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: ..... Date: .....

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Last Reviewed: October 2018

SCOUTS PARENT INFORMATION (Emergency Contacts)

(REQUIRED FOR EVERY SCOUT PER THE STATE OF COLORADO)

Keep this form with the Scout's BSA Medical Form

Scout's Name (First and Last): _____

Parent Name (First and Last): _____

Parent Home Phone: _____

Parent Cell Phone: _____

Parent Work Phone: _____

Parent Name of Employer: _____

Parent Employer Address: _____

Parent Employer City, State, Zip Code: _____

Scout: ____________________ DOB: __________ Week #: _____ Dates: __________

Troop#: __________ Campsite: __________

Allergies: ____

Medication: **Zyrtec**

Dose/Comments: **1 pill daily - AM** Route: **oral**

Purpose: **seasonal allergies** Pill Count IN/OUT: **Filled out by Camp Staff**

	Sun	Intls	Mon	Intls	Tues	Intls	Wed	Intls	Thurs	Intls	Fri	Intls	Sat	Intls
Time:														
Time:						**Example:**								
Time:		**Our Staff will fill in times medication was administered**												
Time:														
Time:														

Medication:

Dose/Comments: Route:

Purpose: Pill Count IN/OUT:

	Sun	Intls	Mon	Intls	Tues	Intls	Wed	Intls	Thurs	Intls	Fri	Intls	Sat	Intls
Time:														
Time:														
Time:														
Time:														
Time:														

Medication:

Dose/Comments: Route:

Purpose: Pill Count IN/OUT:

	Sun	Intls	Mon	Intls	Tues	Intls	Wed	Intls	Thurs	Intls	Fri	Intls	Sat	Intls
Time:														
Time:														
Time:														
Time:														
Time:														

Medication:

Dose/Comments: Route:

Purpose: Pill Count IN/OUT:

	Sun	Intls	Mon	Intls	Tues	Intls	Wed	Intls	Thurs	Intls	Fri	Intls	Sat	Intls
Time:														
Time:														
Time:														
Time:														
Time:														

Page _____ of _____

Closing

Camp Alexander has developed a plan to decrease the likelihood of COVID-19 transmission. Camp Alexander has shared its plan with local health officials. Staff have and will continue to receive significant training. However, no level of planning can fully eliminate the potential for COVID-19 transmission. Traveling to, participating at, and returning home from Camp Alexander presents risk.

It is essential that each participant, parent or guardian, and volunteer adult leader understands the risks associated prior to attending Camp Alexander. Ultimately it is the responsibility of attendees and their parents or guardians to make the decision that is best for them and their families.

_____

Parent or guardian signature and date

I have read and I understand Camp Alexanders COVID-19 Mitigation Plan document.

Camp Alexander COVID-19 Testing Permission

Camp Alexander is required to obtain permission from the parent or guardian to give a COVID-19 rapid test given by a medical professional at Camp Alexander. This test will only be given to the scout that shows COVID-19 symptoms, identified by our onsite medical professional.

I _____(Print your First and Last Name) authorize that the Camp Alexander Medical Staff to aid in applying COVID-19 rapid test given to my scout _____(Scouts Frist and Last Name) if he/she shows COVID-19 symptoms.

You as the parent or guardian will be called after the test. If the test comes back negative your scout will go back to normal camp activity. If the test comes back positive the scout will be put into quarantine for 10 days.

_____

Parent or guardian signature and date