GARDEN SCHOOL

Jackson Heights, New York Christopher Herman, M.Ed... *Head of School*

Spring 2021

Dear Camp Parent:

We have received your Summer Camp 2021 registration form and deposit and would like to officially welcome your child to camp!

We are required by the DOHMH (Department of Health and Mental Hygiene) to have both a current **Health Form** and an **Aquatic Consent Form** on file for each child in camp. Allergy Alert and Asthma Medication Administration Forms should be completed only if they pertain to campers. Please have these forms completed and returned to us **no later than your child's first day of camp.** In addition, each camper must provide proof of a **negative Covid PCR** test taken **within 1 week of start date**.

Also enclosed is a supply list for each of our programs – Nursery (2), Junior (3/4), Intermediate (5/6), 7-9 Group and 10-13 Group.

Once again, welcome to Summer Camp 2021!

If there are any additional questions, please feel free to call.

Sincerely,

Stella Stenos
Director of Garden Summer Program

GARDEN SCHOOL

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Summer Camp Supply List

Nursery, Junior & Intermediate Program

- Reusable cup with your child's name on it for water
- Complete change of clothing in zip lock bags
- Family picture
- Two bathing suits to be taken home each night
- A hooded towel to be taken home each night
- Water shoes
- Waterproof bag
- Hat and spray on sunscreen
- Diapers and wipes (Nursery only)
- Light resting blanket or towel for full-day children (Nursery & Junior program only)
- Face mask
- Lunch from home

7-13 Group

- Two bathing suits
- A beach towel
- Shoes to walk to and from the pool
- Hat and sunscreen
- Reusable water bottle
- Waterproof bag
- Sunscreen
- Lunch from home
- Face mask

NOTES

- First day of camp is June 28th, 2021
- Bus notification – you will be contacted the weekend before camp begins with the approximate time of pick up. Thank you for your patience as the first few days of transportation are not always smooth as we learn the most efficient routes. Pick-up times will become consistent.
- Camp ***will not*** be in session Monday, July 5, 2021 in observance of Independence Day.

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/___

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ___

City/Borough | State | Zip Code | School/Center/Camp Name | District ___ Number ___ | Phone Numbers: Home ___ Cell ___ Work ___

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Attach MAF in in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status: ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes (attach MAF)
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis (latent infection or disease)
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ **Addendum attached.**

Medications (attach MAF if in-school medication needed)

☐ None ☐ Yes (list below)

_____

_____

_____

_____

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference (age ≤2 yrs) _____ cm (___ ___ %ile)

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

☐ Physical Exam WNL

	Nl	Abnl
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes (list below)

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment (annually, age 6 mo-6 yrs)	___/___/___	☐ At risk (do BLL) ☐ Not at risk
Child Care Only		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ Nl ☐ Abnl ☐ Referred
OAE	___/___/___	☐ Nl ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ Nl ☐ Abnl ☐ Referred

Vision	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ Nl ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No

Urgent need for dental referral (pain, swelling, infection) ☐ Yes ☐ No

Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** (list) — **ICD-10 Code**

_____ _____

_____ _____

_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree (print) | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY PRACTITIONER I.D.

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER:

FORM ID#

GARDEN SCHOOL

Jackson Heights, New York

Christopher Herman, M.Ed... *Head of School*

Aquatic Consent Form

I do hereby give consent for my child, _____, age, _____, to participate in the Aquatics Program at the Garden Summer Camp for Summer 2021 under the supervision of the Aquatics Director.

Signature: _____

Relationship to Child: _____

Date: _____

Daytime Telephone: _____

GARDEN SCHOOL

Jackson Heights, New York Christopher Herman, M.Ed... *Head of School*

Garden Camp Medical Consent

Student's Name _____ Date of Birth _____

Address _____

_____

Telephone _____

Parent/Guardian _____

Emergency Contact Number _____

Parent/Guardian 2 _____

Emergency Contact Number _____

Pediatrician Name _____

Pediatrician Phone _____ Pediatrician Fax _____

Parent/Guardian will be notified as quickly as possible in case of an emergency. Please sign below to grant Garden School and its agents permission to dispense over-the-counter medications as needed and to make decisions (including calling an ambulance) to secure medical treatment in an emergency.

Parent/Guardian Signature _____ Date _____

GARDEN SCHOOL

Jackson Heights, New York

Christopher Herman, M.Ed... *Head of School*

Allergy Alert Form
Summer Camp 2021

This form is to be used for all allergies, including food allergies.

Student's Name _____

Date of Birth _____ Grade _____

Allergic to: _____

_____

How long before symptoms appear? _____

What symptoms does the child experience?

Mouth: _____

Throat: _____

Skin: _____

GI Tract: _____

Lungs: _____

Heart: _____

Emergency action to be taken:

If ingestion and/or contact is suspected: _____

_____

If epipen is prescribed:

- Administer epipen and call 911.
- Tell the dispatcher, "_____ allergy anaphylaxis. Epipen given at _____ (time)."
- Remain on the phone until dismissed by dispatcher.

If other medication is prescribed, please specify type, treatment and dosage:

_____

_____

Parent/Guardian: _____ Phone _____

Parent/Guardian: _____ Phone _____

Parent/Guardian's Signature _____ Date _____

Physician's Signature _____ Date _____

Stamp here with name and license number

Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year **2020-2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name First Name Middle Initial | Date of Birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) | ☐ Male ☐ Female

OSIS # _____ DOE District ___ Grade/Class _____

School ATSDBN/Name Address, and Borough:

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other: _____

Control *(see NAEPP Guidelines)*
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
- ☐ Unknown

Severity *(see NAEPP Guidelines)*
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	Y ☐ N ☐ U ☐	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	Y ☐ N ☐ U ☐	
History of asthma-related PICU admissions (ever)	Y ☐ N ☐ U ☐	
Received oral steroids within past 12 months	Y ☐ N ☐ U ☐	____ times last : __ __ / __ __ / __ __
History of asthma-related ER visits within past 12 months History of	Y ☐ N ☐ U ☐	____ times
asthma-related hospitalizations within past 12 months History of	Y ☐ N ☐ U ☐	____ times
food allergy or eczema, specify: _____	Y ☐ N ☐ U ☐	

Student Skill Level *(Select the most appropriate option)*
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers under adult supervision

☐ Independent Student: student is self-carry/self-administer
I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

_____ Practitioner Initials

Quick Relief In-School Medication

☐ **Albuterol** *[Only generic Albuterol MDI is provided by school for shared usage] (plus individual spacer)*: ☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standard Order: Give 2 puffs q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath.
Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress: Call 911 and give 6 puffs; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** 2 puffs @ noon for 5 school days.

Special Instructions: _____

☐ **Other**: Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Give ___ puffs/____AMP q ___ hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress: Call 911 and give ___ puffs/ ___ AMP; may repeat 20 minutes until EMS arrives.

☐ **Pre-exercise:** ___ puffs/___ AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** ___ puffs/___ AMP @ noon for 5 school days

Special Instructions: _____

Controller Medications for In-School Administration

(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ **Fluticasone** [Only *Flovent® 110 mcg MDI is provided by school for shared usage*]
☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standing Daily Dose: ___ puffs ONCE a day at ___ AM

Special Instructions: _____

☐ **Other ICS Standing Daily Dose:**
Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Home Medications *(Include over the counter)*

☐ Reliever _____ ☐ Controller _____ ☐ Other _____

Health Care Practitioner (Please print name and circle one: MD, DO, NP, PA) Last First | Signature | Date __ __ / __ __ / __ __ __ __

Address | Tel. (_ _ _) _ _ _ - _ _ _ _ | Fax (_ _ _) _ _ _ - _ _ _ _ | NPI # _ _ _ _ _ _ _ _ _ _

Email Address | NYS License # **(Required)** | CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. | REV 4/20

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 →

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year **2020-2021**

Please return to school nurse. Forms submitted after June 1, 2020 may delay processing for new school year.

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment, including non-albuterol inhalers.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma medicine is not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the doctor's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
   - When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner may fill out a new MAF so my child can continue to receive health services through OSH. My health care practitioner or the OSH health care practitioner will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
   - This form represents my consent and request for the asthma services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved self-administered medications with your child on a school trip day and/or after-school program in order for he/she to have it available. Stock medications are for use by OSH staff in school only.

Student Last Name _____ First _____ MI _____ Date of Birth ___/___/_____

School ATSDBN/Name _____ **District** _____ **Borough** _____

Parent/Guardian Print Name: _____ SIGN HERE **Signature:** _____

Date Signed ___/___/_____ Parent/Guardian's Address: _____

Cell Phone (___)___-____ Other Phone (___)___-____ **Email:** _____

Other Emergency Contact Name/Relationship: _____ Emergency Contact Phone: (___)___-____

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number: _____ ☐ 504 ☐ IEP ☐ Other

Received By Name: _____ Date __/__/__ | Reviewed By Name: _____ Date __/__/__

Services Provided By
☐ Nurse/NP
☐ School-Based Health Center
☐ OSH Public Health Advisor *(For supervised students only)*
☐ OSH Asthma Case Manager *(For supervised students only)*

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Modified ☐ Not Modified

Signature and Title (RN OR MD/DO/NP): _____

Confidential information should not be sent by email

FOR PRINT USE ONLY

GARDEN SCHOOL

Jackson Heights, New York

Christopher Herman, M.Ed... *Head of School*

Photo Release Form

Parent / Guardian Name: _____

Child(ren) Name(s): _____

Grade(s): _____

Please check appropriate box to indicate your preference:

☐ I do not wish my child's pictures to be used for any purpose.

☐ I allow my child's picture to be taken to be used in marketing materials

Parent / Guardian Signature _____ Date _____