Dear Prospective Camper:

Welcome to the Marine Science Enrichment Program! We're excited to invite you to an amazing week of exploration in Long Island's ecologically significant areas. Your home base, the Cliff House at Dorothy P. Flint 4-H camp, offers stunning views of the Long Island Sound.

Throughout the week, we'll embark on adventures to places like Montauk Point, Squire's Pond Salt Marsh, Elizabeth A. Morton National Wildlife Refuge, and the Sunken Forest at Fire Island National Seashore. Get ready for hands-on experiences, such as building and flying remotely operated vehicles, exploring the Long Island Aquarium, and trawling for marine wildlife aboard one of Stony Brook University's research vessels.

Our passionate and experienced staff is dedicated to making this a memorable journey of exploration, learning, and fun. We hope to share this incredible experience with you.

Thank you,

Marine Studies Enrichment Program Staff

Dear Parents and Guardians:

Please review all the below information and guidance before completing and submitting the health form required for the Marine Studies Enrichment Program (MSEP). The below information will help you ensure the mandatory health forms are not missing information.

- **All forms must be received by Jill Lau on the date they are due.** We need time to review forms and time to request additional information and corrections.
    - Submission Information
        - Email: JLau@wsboces.org Fax: (631) 623 - 4912

- **All information on all forms must be complete and legible**; this includes signatures, physician stamps, emergency contacts, phone numbers, vaccine information, doctor and health insurance information. All of this information is required by the NYS and Suffolk County Departments of Health.
    - Forms that are incomplete will be returned. Returned forms will result in a processing delay. A processing delay could jeopardize participation in the program.
    - For guidance, please contact Jennifer Cressy, or Michael Langer
        - Jennifer Cressy (JCressy@wsboces.org)
        - Michael Langer (MLanger@wsboces.org)
        - Office Phone Number (631) 360 - 3652

- If medication needs to be administered (prescription and/or over-the-counter), the doctor-signed *"Parent and Provider Permission to Administer Medication"* form must be completed for each medication (including over-the-counter medication) and attached to the health form. Add pages if necessary.
    - All written instructions on the *"Parent and Provider Permission to Administer Medication"* form must be legible.

- The *"Provider Attestation and Parent Permissions for Independent Carry and Use"* form should only be completed for persons carrying medication that requires rapid self-administration for example, but not limited to, allergy meds or an epinephrine auto-injector, inhaled respiratory rescue medication for asthma, or medication for diabetes management.
    - This form should also be complete and legible.

Thank you for your attention to these details.

RESIDENTIAL HEALTH INFORMATION FORM (Part 1)

TO BE COMPLETED BY STUDENT'S PARENT OR GUARDIAN

ALL BELOW FIELDS ARE REQUIRED

Student Information

Name of Student _____ School District _____

Address _____

Age _____ DOB _____/_____/____ Home Phone (__)_____ Gender _____

Parent/Guardian Contact 1

Name of Parent/Guardian_____

Address_____

Home Phone (___)_____ Cell Phone (___)_____Email_____

Business Address:_____ Phone (__)_____

*** Parent/Guardian Contact 2 (If Applicable)**

Name of Parent/Guardian_____

Address_____

Home Phone (__)_____Cell Phone (___)_____ Email_____

Business Address:_____Phone (__)_____

Name and phone numbers of two ADDITIONAL adults we can contact in the event you cannot be reached:

Name_____ Relationship_____ Phone (__)_____Cell Phone (___)_ _____

Name_____ Relationship_____ Phone(___)_____Cell Phone (___)_____

Name of Family Doctor_____ Phone (__)_____

Health Insurance Carrier_____ Policy #_____

By signing below, I attest that all of the above information is accurate and up to date. I also give permission to Marine Studies Enrichment Program staff to contact any of the above noted parties.

SIGNATURE_____ DATE_____

(Parent or Legal Guardian)

RESIDENTIAL HEALTH INFORMATION FORM (Part 2)
TO BE COMPLETED BY STUDENT'S PARENT OR GUARDIAN

ALL BELOW FIELDS ARE REQUIRED

Does your child have any known limitations that would prevent them from participating in any physical activities?

Please circle: Yes / No

If you circled yes to the above question, please state and describe the limitations in the space below.

_____

_____

_____.

Does your child have any known special needs? (i.e. ADHD, Anxiety, etc.)

Please circle: Yes / No

If you circled yes to the above question, please describe in the space below.

_____

_____

_____.

Does your child have any dietary restrictions?

Please circle: Yes / No

If you circled yes to the above question, please describe in the space below.

_____

_____.

My child has permission to carry and use sunscreen and/or insect repellent. Camp staff can assist with the application of sunscreen and/or insect repellent if my child is unable to do so, provided my child requests the assistance.

The student herein described has my permission to engage in all prescribed activities except as noted by me and/or the student's physician. In the event I cannot be reached in an emergency, I hereby give my permission to the physician, selected by the teacher in charge, to provide first aid treatment as needed.

SIGNATURE_____ DATE_____

Parent or Legal Guardian

RESIDENTIAL HEALTH INFORMATION FORM
TO BE COMPLETED BY STUDENT'S *PHYSICIAN OR NURSE*

Name of Patient _____ School District _____

Address _____

Age _____ DOB ____/____/____ Home Phone (___) _____ Gender _____

Name of Parent/Guardian_____ Cell Phone (___)_____

Please include a complete copy of immunization records. Your record must include the following immunizations: Tetanus, Measles, Varicella, Diphtheria, Rubella, Pertussis, Mumps, Poliomyelitis, Meningococcal, Hepatitis B, Haemophilus B.

1. List any health conditions, such as heart disease, diabetes, epilepsy, asthma, or any chronic condition, etc.:

2. Does the student have any condition that requires medication? If yes, what is the condition and treatment?

****If medication needs to be administered (prescription and/or over-the-counter), the doctor-signed "Parent and Provider Permission to Administer Medication" form must be completed for each medication and attached to this health form. Prescription medication must be sent in original pharmacy containers.****

4. Does the patient carry an pi-pen and/or have diabetes? _____ If yes, the "Provider Attestation and Parent Permissions for Independent Medication Carry and Use" must also be completed on the "Parent and Provider Permission to Administer Medication" form.

5. Please indicate if the patient has an allergy, its symptoms and the treatment below. If no, please write "no."

Type	Yes / No	Specify	Symptoms	Treatment
Food				
Insect sting				
Medication				
Other				

6. Has the patient been exposed to any communicable diseases in the past 21 days?

Circle: Yes / No *If yes, please indicate disease(s).

7. Do you know of any health factor that makes it advisable for the patient to follow a limited program of physical activity?

Circle Yes / No If yes, please state and describe any limitations.

8. Does patient wear glasses? Circle: Yes / No

9. Contact lenses? Circle: Yes / No

10 Does patient have any dietary restrictions? Circle: Yes / No

If yes, please describe.

STAMP

SIGNATURE_____DATE_____

Physician or Nurse (Circle One: MD, DO, NP, PA or RN)

PROVIDER AND PARENT PERMISSION TO ADMINISTER MEDICATION

*To be completed ONLY if student is required to take/carry medications during this program

To Be Completed By Parent

Child's Name: _____ DOB: _____

I request the program staff give the medication listed on this plan; staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child.

_____ _____

Parent/Guardian Signature Date

_____ _____

Email Address Phone NumberWhere We Can Reach You Cell: Yes or No

To Be Completed By Health Care Provider

Diagnosis #1 _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations_____ ICD Code _____

Diagnosis #2 _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations_____ ICD Code _____

(Attach additional sheets as necessary)

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)

NYS law requires both provider attestation that the student has demonstrated they can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option during program. Check this box and attach the attestation to this form to request this option.

Name/Title of Prescriber:_____ Prescriber's Signature:_____ Date:_____ Phone:_____ Email:_____	STAMP

INDEPENDENT MEDICATION CARRY AND USE
PROVIDER ATTESTATION AND PARENT PERMISSIONS

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a participant to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a participant to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ DOB: _____

Health Care Provider Permission for Independent Use and Carry I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently during the Marine Studies Enrichment Program. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

- ☐ This student is diagnosed with:
- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

SIGNATURE_____ DATE_____ Physician or Nurse (Circle One: MD, DO, NP, PA or RN)	STAMP

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently during the Marine Studies Enrichment Program. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

PARENT AUTHORIZATION FORM

1. AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM THEIR PARENTS

Name of Student_____Age_____Gender_____

Address_____Phone (_____)_____

Name of Parent/Guardian_____

Address (if different from above)_____

Home Phone (____)_____ Work Phone (____)_____Cell Phone (____)_____

Parent email_____ Student email_____

School District_____School_____

Name of Family Doctor_____Phone (____)_____

Health Insurance Carrier_____ Policy #_____

I, the undersigned, parent or legal guardian of above-named student, a minor, am familiar with the program and the general nature of activities planned during the Western Suffolk BOCES Marine Studies Enrichment Program, and to the best of my knowledge the above Information Is correct and my child Is capable of participating in and has permission to engage in all activities.

I do hereby authorize Jennifer Cressy and/or Michael Langer (Lead Teachers) or John Shiels (Program Coordinator) as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician at the nearest hospital with facilities appropriate to my child's Injury/Illness. I agree to the release of any records necessary for medical treatment or insurance purposes. This authorization shall remain effective until (day after the last day of the trip) unless sooner revoked In writing delivered by said agents.

2. FIELD TRIP AUTHORIZATION

The above-named student has my permission to participate in all field trips as part of the Western Suffolk BOCES Marine Studies Enrichment Program including (but not limited to):
Sunken Meadow Creek and Salt Marsh, Kings Park; SUNY Stony Brook Boat Excursion, Southampton; West Sayville Maritime Museum, West Sayville; *Sayville Ferry to Sunken Forest, Fire Island; Old Ponquogue Bridge Marine Park/Fishing Pier, Hampton Bays; *Ponquogue Beach, Hampton Bays; Elizabeth Morton Wildlife Refuge, Noyac; Squire Pond Salt Marsh, Hampton Bays; Atlantic Marine Conservation Society, Westhampton.

Regarding boat activities: if prone to motion sickness, participants may wish to consult a doctor or pharmacist to purchase an over-the-counter medication for use while on boats (relatively flat water). **NOTE: These, as with any medications, need to be documented with physician approval on residential health form.**

3. PHOTO RELEASE ☐

Please check the box if you DO NOT give permission for photos of your child participating in the program to be used by Western Suffolk BOCES.

SIGNATURE_____DATE_____

Parent or Legal Guardian