

## **Dear 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 no later than Friday May 29<sup>th</sup>.** We need time to review forms and time to request additional information and corrections.
  - Submission Information
    - Email: [JLau@wsboces.org](mailto: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](mailto:JCressy@wsboces.org))
    - Michael Langer ([MLanger@wsboces.org](mailto: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.

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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.

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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.

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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 epi-pen, inhaler, and/or have diabetes? \_\_\_\_\_ If yes, the "Provider and Parent Permissions to Administer Medication" form AND Independent Medication Carry and Use Provider Attestation and Parent Permissions" form must also be completed (pages 4 and 5, indicated on top right of each page).

5. Please indicate if the patient has an allergy, its symptoms and the treatment below. If no, please write "NO" in all fields that don't apply.

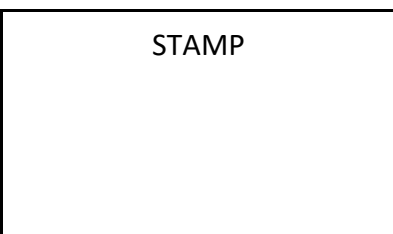
Table with 5 columns: Type, Yes / No, Specify, Symptoms, Treatment. Rows include Food, Insect sting, Medication, Other.

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.



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 Number Where 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 the above box and attach the attestation to this form to request this option.

Name/Title of Prescriber: \_\_\_\_\_

STAMP

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## 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 (MSEP) including, but not limited to:

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; Long Island Aquarium, Riverhead; Montauk Point Lighthouse, Montauk

**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

← ONLY CHECK IF YOU DO NOT WANT PHOTOS TAKEN

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

## MSEP CLOTHING AND EQUIPMENT LIST - OCM

Clothing should be comfortable and practical. All items should be marked for identification purposes. Because Western Suffolk BOCES cannot be responsible for lost articles, it is recommended that students leave valuable belongings at home.

Luggage should consist of one suitcase or pack, one small carry-on type bag, a sleeping bag/blankets, and a pillow. Students should have sufficient clothing for one week.  
The list below can help in your planning.

<p><b><u>Bedding &amp; Toiletries</u></b>          1 Sleeping Bag or 2 blankets          1 Set sheets          1 Pillow and case          1 Shower Towel          1 Beach towel          1 Hand Towel          1 Washcloth          1 Toothbrush          Toothpaste          Soap          Shampoo          Comb/Brush          Other personal items</p>	<p><b><u>Clothing</u></b>          1 Rain Jacket/Windbreaker          1 Sweatshirt          1 Sweatpants          6 Pair Socks          6 Underwear          6 T-shirts          2 Long-sleeved Shirts          5 Shorts          2 Jeans          1-2 bathing suits          Pajamas</p>
<p><b><u>Other Items</u></b>          Sunblock**          Hat with Brim          Lip Balm          Flashlight and batteries          Small Daypack          Resealable Water Bottle**          White T-Shirt for Fish Art Souvenir**          Food money for transport to and from Long Island**</p>	<p><b><u>Footwear</u></b>          1 Pair Sneakers          1 Pair Shower Shoes          1 Pair Water Shoes or Old Sneakers, foot completely enclosed**</p>
<p><b><u>Optional</u></b>          Notebook          Pen/pencils          Insect Repellant          Alarm Clock          Camera          Money for souvenirs</p>	<p><b><u>IMPORTANT!!</u></b></p> <ul style="list-style-type: none"> <li>● Items marked ** are <b>mandatory items!</b></li> <li>● **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 the health form. Prescription and over the counter medication must be sent in original containers.**</li> </ul>

*Snacks and personal food items are not to be brought into camp. However, if you have special food requirements, please let us know prior to your arrival. We will do our best to accommodate.*

*While there is no air conditioning at camp, each sleeping room is provided with a fan. We also take advantage of the cool breeze that blows off of the Long Island Sound!*