OCMBOES
Committed to Your Success
Science Center

OCM BOCES/SUNY ESF
Adirondack Field Studies Summer Program
Cranberry Lake

Residential Health Information, Medical Treatment of Minors, Field Trip Parent Authorization Form
Please Read Thoroughly Before Signing

Fill out this form carefully. Have your signature witnessed by another adult.

A child may be treated without parental consent when a physician determines a true emergency exists. That means the doctor determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health.

Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child may need unexpected care which is not, however a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

This is a legal document. With it you have appointed the chaperones, teachers, graduate students, administrators and other officials or designees of OCM BOCES and/or SUNY ESF to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions when you know it will be hard to contact you.

Students will be staying at SUNY ESF's facility at Cranberry Lake. This facility cannot be reached by road. Therefore, students must be transported by boat to the field station. By signing this form, you give permission for the student named on the back of this form to travel by boat to the field station.

I further understand that my child must obey all the rules and regulations set forth by the program instructors. Failure to do so will result in **immediate** expulsion. If this should occur, parents are responsible for transporting children home.

Reminder: This is a school trip. Weapons, including camping knives are **NOT** permitted.

After you complete this form, have your child return it to school. If your child needs unexpected medical treatment, the responsible adult(s) will present this document to the appropriate person—physician, dentist or hospital representative.

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Date of trip: From 8/5/24 (Monday) to 8/11/24 (Sunday)

Residential Health Information, Medical Treatment of Minors, Field Trip Parent Authorization Form

Name of Student: _____ For SUNY ESF credit please complete online registration.

Address: _____ School District: _____

_____ Date of Birth: _____ GENDER: ☐ Male ☐ Female

Phone: (_____) _____ Pick-up Location: ☐ Homer HS ☐ Main Campus Liverpool

Parent/Guardian Name: _____ Phone: (_____) _____

Work Address: _____ Parent/Guardian E-Mail Address:

_____ _____

Another adult who does not live with above named Parent/Guardian who can be contacted **in case of emergency**:

Name: _____ Phone: (_____) _____

Family Doctor: _____ Phone: (_____) _____

Health Insurance Carrier: _____ Policy #: _____

1. Date of most recent immunizations: [IMPORTANT: The NYS Dept. of Health requires that this section be completed and that all immunizations be up to date. You may attach a copy of your records.]
   Diphtheria/Tetanus ____/____/____ Mumps ____/____/____ Measles ____/____/____
   Rubella ____/____/____ Polio ____/____/____ Hepatitis B ____/____/____
   Haemophilus Influenza B ____/____/____ Varicella (chicken pox) ____/____/____
2. List any known medication or other allergies: (Sulfa? Penicillin? Aspirin?) [**complete Allergy Action Plan form**]
   _____
3. Medications (prescription and OTC) presently using: [**complete Student Medication Form**]
   _____
4. List any exposure to communicable diseases in past 21 days: _____
5. Describe any factor limiting physical activity of student: _____
6. Swimming ability: ___ Non-swimmer ____ Beginner ____ Intermediate ____ Advanced
7. List any dietary restrictions: _____
8. Do we have permission to give your child aspirin or aspirin substitute for minor pain? ☐No ☐Yes [**complete Student Medication Form**]
9. Health History (check all that apply):

___ Asthma/Respiratory	___ Dental needs	___ Epilepsy	___ Heart Disease/Defect
___ Back problems	___ Diabetes	___ Eyewear	___ Psychiatric Diagnosis
___ Bleeding Disorder	___ Ear Infections	___ Fainting spells	___ Sleep walking
___ Convulsions	___ Eating Disorder	___ Headaches	___ Skin Problems

10. Permission to apply/use SUNSCREEN: ☐ Yes ☐ No

The above information is true to the best of my knowledge. **I have read the back of this form** and understand that by signing below I am agreeing with the provisions outlined there and authorize the chaperones, health professionals, teachers, administrators and other officials of OCM BOCES or SUNY ESF to provide first aid or authorize medical treatment for my child in the event I cannot be reached. **Reminder**: This is a school trip. Weapons, including camping knives are **NOT** permitted.

Parent/Guardian Signature: _____ Date: _____

Witness signature: _____ Date: _____

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Date of trip: From 8/5/2024 (Monday) to 8/11/2024 (Sunday)

Student Medication Form

Student medication will be permitted on the Adirondack Field Studies trip only with signed consent from the student's parent and healthcare provider. All prescribed and over-the-counter medication must be registered with our nurse, **CHRISTINA BEAM**. All medication must be in the original labeled container, which specifies the student's name and date of birth, the type of medication, the dosage and times of administration.

Please Complete Section A or B

Section A / Self-Directed Student

_____ (student's name) is capable of self-administering medication and allowed to take the following medication(s) while on the Adirondack Field Studies trip.

Medication Name	Instructions

_____ _____

Parent Signature / Date Health Care Provider Signature / Date

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Section B / Non Self-Directed Student

_____ (student's name) is not capable of self-administering medication and will require assistance with the following medication(s) while on the Adirondack Field Studies trip.

Medication Name	Instructions

_____ _____

Parent Signature / Date Health Care Provider Signature / Date

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Allergy Action Plan

Student Name: _____ DOB: ___/___/_____ ☐Male ☐Female

Allergic to: _____

Weight: _____ lbs. Asthma: ☐Yes (higher risk for a severe reaction) ☐No

Extremely reactive to the following foods: _____
THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

Any SEVERE SYMPTON after suspected or known ingestion:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or combination of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g. eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

1. INJECT PEINEPHRINE IMMEDIATELY
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications* as needed
   -Antihistamine
   - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTONS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

1. GIVE ANTIHISTAMINE
2. Stay with student; alert healthcare professionals & parent
3. If symptoms progress (see above). USE EPINEPHRINE
4. Begin monitoring (see box below)

MEDICATIONS/DOSES

Epinephrine (brand & dose w/directions): _____
Antihistamine (brand & dose): _____
Other (e.g. inhaler-bronchodilator if asthmatic): _____

Contacts: CALL 911 !

Physician Name: _____ Phone Number: (____) ____-_____

Parent/Guardian Name: _____ Phone Number: (____) ____-_____

Other Emergency Contact(s):

Name/Relationship: _____ Phone Number: (____) ____-_____

_____ _____ _____ _____
Parent/Guardian Signature Date Physician/Healthcare Professional Signature Date

Notification Regarding Photos

Complete top portion **only** if you do **NOT** want your child's picture, name or schoolwork to be used in newspaper articles, video, and/or BOCES publications, including our BOCES' website

During the Adirondack and/or Marine Studies programs, your son or daughter may have the opportunity to have his/her photo taken and/or written work published in connection with this program. Your child's photo (image), program work and/or name may be published in local newspapers, posted (displayed) on the BOCES' Internet site, or used by the requesting organization (local TV or print media) for programming, i.e., backup and their news stories.

If you do **NOT** want your child's picture, name or schoolwork to be used in newspaper articles, video, and/or BOCES publications, including our BOCES' website, please sign this form. Also share this information with your child, so that they will know to avoid pictures, if necessary.

☐ I do **NOT** give permission for photos

_____
Student's Name

_____ _____
Parent/Guardian Signature Date

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☐ I give permission for photos

_____
Student's Name

_____ _____
Parent/Guardian Signature Date

ESF in the High School
K-12 Outreach Initiative

Date: August 5-11, 2024
Students will be awarded one credit a grade from SUNY ESF for EFB105

IMPORTANT: For this program your High School is OCM BOCES, *do* <u>not</u> select your home school.

1. Invitee Information:
   a. Enter information using proper Upper and Lowercase typing. Example: Jennifer, not jennifer
   b. Use your LEGAL name. Example: Michael, not Mike
   c. School District: For this program your district is **OCM BOCES, not your high school,** which is found by scrolling down the options
2. Personal Information:
   a. Middle Initial: If you don't have a middle name use a dash (–)
   b. Parent/Guardian: Enter parent/guardian who takes care of your school paperwork
   c. Social Security Number: This is required, if you don't have one or can't find it at the time of registration enter a placeholder using only number 9. (using this format ##-###-####)
   d. Ethnic Origin: Per SUNY, these are the only 5 choices
   e. Current Year in School: For this program select the year you are moving up to, not the one you are leaving in June.
   f. Gender: Per SUNY, these are the only three options to choose from
3. Contact Information:
   a. Home Address: Where you reside and would receive mail
   b. Phone: Cell or landline
4. Additional Information Page:
   a. If you have taken other ESF courses select YES
   b. Select YES as by registering you agree to pay, regardless of who is paying
5. School Lunch Eligibility: We keep this information for demographic data. It does not affect your fee for this course.
6. Course Registration: Select Cranberry Lake/BOCES EFB496, and ignore time, our system requires something.
7. Submit Payment:
   a. Please pay using a *Credit Card* at the time of registration.
   b. If you plan on sending in a check or money order, select *Check*. The ESF fee is separate from the BOCES program cost that is covered by your district.
   c. We cannot take *Cash*.
8. Finish: when you are done with payment select Finish and a confirmation email will be sent to you. To attend this program you are required to sign up and pay for this 1 credit course. Failure to do so will prevent you from attending.

Any questions?

Registration: Contact Maura H. Stefl at mhstefl@esf.edu or 315-470-6811 **OR** Dan Collins at dbcollin@esf.edu or 315-470-6553

During the hours of 8:00 am to 4:00 pm, Monday-Tuesday or Friday 8:00 am to 12 noon. If we are unavailable, please leave a message with your name and phone number.

REGISTRATION MUST BE COMPLETED BY July 26, 2024

Program: Any questions regarding the program should be directed to Cindy Zajac, OCM BOCES czajac@ocmboces.org or 315-433-2671

REGISTRATION LINK: https://cvent.me/AkveOB