INFORMED CONSENT

The State of CT Office of Early Childhood (Coronavirus Memo #18) requires camps to inform and obtain consent from all staff and parent(s) of children registered for camp that they have received the following notice:

- People who are 65 years and older and people of any age who have serious underlying medical conditions or are at higher risk for severe illness from COVID-19 are recommended to stay at home. A list of medical conditions associated with a higher risk for severe illness from COVID-19 can be found in CDC’s guidance. Individuals and families should consult their healthcare provider to determine whether they have medical conditions that place them at risk.

- Staff and children living in households with individuals who are 65 years and older OR have higher risk for severe illness from COVID-19 are recommended to stay home.

I hereby attest that I have been informed of the above notice pertaining to the coronavirus:

_________________________________________  _______________________________________
Signature of Staff or Parent/Guardian  Printed Name

_________________________________________  __________________________
Child’s Name (if a parent/guardian)  Date

---

1 Includes chronic lung disease or moderate to severe asthma, serious heart conditions, immunocompromised (cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications), severe obesity (body mass index [BMI] of 40 or higher), diabetes, chronic kidney disease undergoing dialysis and liver disease. Individuals should consult their healthcare provider to determine whether they have medical conditions that place them at increased risk for severe illness from COVID-19.
Camper Name: __________________________  Name/wk of Camp: ________________

Pre-Camp Health Screening

Dear Camp families,

In an effort to minimize illness at camp we ask that you check on the health of your camper daily beginning 14 days prior to camp. The best camp sessions start with healthy campers and this begins at home. Please bring this completed form to camp on opening day.

Please indicate if your camper has any of the following symptoms prior to camp and record a temperature daily. If any temperature or symptoms are present, please have your camper evaluated by a licensed provider and contact camp for further guidance.

Symptoms:

• Cough
• Shortness of breath or difficulty breathing
• Fever
• Chills
• Muscle Pain
• Sore throat
• New loss of taste or smell
• Nausea
• Vomiting
• Diarrhea

Please initial

1. My child has not been around anyone with any of the listed symptoms or diagnosis of COVID19 in the 14 days before the start of camp. Initial ________

2. My child has adhered to our state’s guidelines regarding COVID19. Initial ________

<table>
<thead>
<tr>
<th>Day:</th>
<th>14</th>
<th>13</th>
<th>12</th>
<th>11</th>
<th>10</th>
<th>9</th>
<th>8</th>
</tr>
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<tbody>
<tr>
<td>Temp/ sympt</td>
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</table>

Start date of temperature/symptom screening: ________

Day: 7 6 5 4 3 2 1

Temp/ sympt

Our signature indicates that we completed this health screening daily for 14 days prior to camp and to the best of our ability. We understand that arriving to camp healthy is vital to a healthy camp for all campers.

Parent Signature: ____________________________________________ Date: __________

Camper Signature: ___________________________________________ Date: __________
HEALTH AND IMMUNIZATION PAPERWORK FOR NEW AND RETURNING CAMPERS

(Parents: If you are unable to obtain the required health forms from your child’s
physician, please read the State ruling below and follow the instructions to submit
proper and acceptable paperwork to Project Oceanology):

In accordance with the CT State Office of Early Childhood:

Health and immunization records for children that previously attended the camp that
expire during the declared emergency are acceptable. Health and immunization records
for children that have been attending a legally operating child care program or school
that has been temporarily closed due to COVID-19 are not required — provided the parent
attests in writing that the child is up-to-date with their physical examination and
immunizations and provides information regarding any disabilities and/or special health
care needs.

In addition, at the direction of our camp physician, your child MUST have ALL the
immunizations listed on our health form. There are no exceptions permitted. If your
child does not have all the required immunizations, do not sign this waiver and notify us
to cancel your child’s registration and refund camp tuition.

If the above situation applies to your child, please check the appropriate box below,
print, sign and date this statement and upload this document in place of your child’s
health form. If applicable, please complete the Individual Plan of Care form to provide
information regarding any disabilities and/or special health care needs.

___ My child, ____________________________________________________________ attended Project O summer
camp in 2019 and I submitted the required Health and Immunization records at
that time. I attest that my child is up-to-date on their physical and all
immunizations required by Project Oceanology.

___ My child, ____________________________________________________________ has attended a legally
operating public/private school for the 2019-20 school year which has been
temporarily closed due to COVID-19. I attest that my child is up-to-date on their
physical and all immunizations required by Project Oceanology.

Name of Parent (Print): ___________________________________ Date: __________

Signature of Parent: __________________________________________________________________________
YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years from Date of Last Examination (An updated health form is required each year of camp even if exam is not due)

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name_________________________________________ Date of Birth_____________ Phone________________

Guardian_____________________________________ Address__________________

Emergency Contact___________________________ Telephone________________

Date of Arrival at Camp: ___________________________ Departure Date: ___________________________

-----------------------------------------------------------------------------------------------------------------------------

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Last Exam ____/____/____

☐ May participate in all activities
☐ May participate except for:

Medical information pertinent to routine care and emergencies:

Is this individual taking prescription or over the counter medication(s)?  ☐ YES  ☐ NO If yes, indicate names of medication(s):

Does the individual have allergies?  ☐ YES  ☐ NO Explain:

Is the individual on a special diet?  ☐ YES  ☐ NO Explain:

Does the individual have special needs? ☐ YES  ☐ NO Explain:

Is this individual taking prescription or over the counter medication(s)?

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Rubella</td>
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<tr>
<td>Chickenpox</td>
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<td>Tetanus</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Diphtheria</td>
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<tr>
<td>Pertussis</td>
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<tr>
<td>Pneumococcal conjugate</td>
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<tr>
<td>Polio</td>
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</table>

Comments: ____________________________________________

Print name of medical care provider: ________________________________________________

Medical care provider’s address: ____________________________________________________

Medical care provider’s: City/Town_________________________ ST________________ Zip Code__________

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number

Rev 12.19
Project Oceanology chooses to have campers self-administer medications under the supervision of certified camp staff and in accordance with CT State Laws. **This does not mean the camper will self carry their medication.** All medications are secured by certified camp staff and distributed to the camper as directed by the Physician’s written order below. **Medications must be in the original container and labeled with child’s name, name of medication, directions for medication’s administration, and date of the prescription.**

**AUTHORIZED PHYSICIAN’S ORDER** (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Date of Birth</th>
<th>Today’s Date</th>
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<tbody>
<tr>
<td>Address of Child</td>
<td>Town</td>
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<tr>
<td>Medication Name/Generic Name of Drug</td>
<td>Controlled Drug? YES</td>
<td>NO</td>
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<tr>
<td>Condition for which drug is being administered:</td>
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<tr>
<td>Specific Instructions for Medication Administration</td>
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<tr>
<td>Dosage</td>
<td>Method/Route</td>
<td></td>
</tr>
<tr>
<td>Time of Administration</td>
<td>If PRN, frequency</td>
<td></td>
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<tr>
<td>Medication shall be administered: Start Date</td>
<td>End Date</td>
<td></td>
</tr>
<tr>
<td>Relevant Side Effects of Medication</td>
<td>None Expected</td>
<td></td>
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<tr>
<td>Explain any allergies, reaction to/negative interaction with food or drugs</td>
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<td></td>
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<tr>
<td>Plan of Management for Side Effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriber’s Name/Title</td>
<td>Phone Number (____)</td>
<td></td>
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<tr>
<td>Prescriber’s Address</td>
<td>Town</td>
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<tr>
<td>Prescriber’s Signature</td>
<td>Date</td>
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**PARENT/GUARDIAN AUTHORIZATION**

- I request that medication be administered to my child as described and directed by Physician above
- I understand and authorize the above ordered medication be administered by my child under the supervision of certified Project O camp staff as directed above and in accordance with CT State Laws
- I understand and authorize the exchange of information between the Prescriber and Project Oceanology to the extent necessary to ensure the safe administration of this medication and to complete camp form requirements.

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<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>Parent/Guardian’s Address</td>
<td>City</td>
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<tr>
<td>Home Phone # (<strong><strong>) _____ - ______ Work Phone # (</strong></strong>) _____ - ______ Cell Phone # (____) _____ - ______</td>
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**Note:** This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)
UNDERSTANDING THE SELF ADMINISTRATION OF MEDICATION FORM

Project Oceanology chooses to have campers self-administer medications under the supervision of trained staff and in accordance with CT State Laws. All medications are secured by Project O staff and distributed to the camper as directed by the Physician’s written order (Form: Authorization for the Self-Administration of Medication by Youth Camp Personnel). All camp staff are certified in medication administration which includes Epi-Pen as well as First Aid/CPR.

The “Authorization for the Self Administration of Medication by Youth Camp Personnel” form is needed for EVERY medication your child brings to camp.

The top half of this form is the Physician’s Written Order (Physician signature required).

The bottom half of the form is the Parent’s consent for self-administration of medication. This does not mean your child will self carry their medication. As stated above, it means your child will self administer their medication when it is distributed to your child by certified Project O staff as directed by the Physician’s written order. We cannot accept medication if this form is not signed by both the Physician and the Parent.

If you have any questions about this procedure or completing the form, please contact us before submitting the form to your child’s physician.
EPI-PEN EMERGENCY HEALTH CARE PLAN

(Only required for EpiPen® prescriptions)

FOR PATIENTS WITH MULTIPLE ALLERGIES REQUIRING AN EpiPen®, USE ONE FORM FOR EACH ALLERGEN

PLEASE NOTE PROJECT OCEANOLogy REQUIRES 2 EPI-PENS FOR CAMP

Camper Name ____________________________

This participant is allergic to: ____________________________________________________________

Prescribing Medical Care Provider: ____________________________ Telephone (___) __________________

Provider’s Address: ________________________________________________________________

Street City State Zip

ASTHMA? □ Yes (high risk for severe reaction) □ No FOOD ALLERGY ____________________________

*Signs of an allergic reaction include, but not limited to the following:

SYSTEMS* SYMPTOMS

MOUTH Itching & swelling of lips, tongue, or mouth
THROAT Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN Hives, itchy rash and/or swelling about the face and/or extremities
GUT Nausea, abdominal cramps, vomiting and/or diarrhea
LUNG Shortness of breath, repetitive coughing, and/or wheezing
HEART “Thready” pulse, light-headedness, “passing-out”

*Above symptoms CAN potentially progress to a life-threatening situation! The severity of symptoms can change quickly.

ACTION: NUMBER THE FOLLOWING FROM 1 to 6, in the correct order necessary for care. (1= 1st step, 2= 2nd step, etc.) If participant ingests, thinks he/she has ingested, insect sting (seen or suspected), etc.

_____ Observe for severe symptoms
_____ Administer EpiPen® before symptoms occur
_____ Administer EpiPen® if symptoms occur
_____ Call 911 (and request paramedic) and transport to ER if EpiPen® given
_____ Call 911 (and request paramedic) and transport to ER if symptoms occur
_____ Administer Benadryl® (dose) ________ or Atarax® (dose) _______

DO NOT HESITATE TO ADMINISTER MEDICATION & CALL 911, EVEN IF PARENT(S) OR PRESCRIBER CANNOT BE REACHED!

__________________________________________

Prescribers’ Signature (MD/APRN/PS)

__________________________________________

Parent/guardian Name (print)

__________________________________________

Parent/guardian Signature

__________________________________________

EMERGENCY CONTACTS

1. __________________________________________ Relation __________ Phone (___) __________
2. __________________________________________ Relation __________ Phone (___) __________
3. __________________________________________ Relation __________ Phone (___) __________

Rev 12.19
Greetings from Project Oceanology!

We are looking forward to a fun and educational week of camp and are pleased your camper will be joining us.

As you prepare your child's medication for camp, please note, it is required that you bring 2 Epi-Pens with your camper for check-in. Our Summer Camp activities take us to the shores of local islands via skiffs and excursions on our EnviroLab research vessels can be as much as an hour away from Project O in open water. If your camper experiences a reaction that requires use of his/her EpiPen, it is important to understand that a remote location by boat may impact the response time for emergency responders, to the point where the effects of the first EpiPen have worn off and a second EpiPen should be administered.

CT state law for licensed youth camps recommends parents provide 2 Epi-Pens. As a safeguard, Project Oceanology is going further to require 2 Epi-Pens for the week your camper is with us.

Please take the time to discuss this with your child's physician. If you would like to discuss this further, you can reach out to one of our Camp Director’s, Marissa Mackewicz or Deb Sayer via email: projecto@oceanology.org or call: 860.445.9007.

(This note is for informational purposes only – please submit only the Epi-Pen form after completion)
# Asthma Action Plan

**Asthma and Allergy Foundation of America**

**DOES NOT APPLY TO MY CAMPER**

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<th>Date:</th>
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<tr>
<th>Doctor:</th>
<th>Medical Record #:</th>
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<tr>
<th>Doctor's Phone #: Day</th>
<th>Night/Weekend</th>
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<th>Emergency Contact:</th>
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<table>
<thead>
<tr>
<th>Doctor's Signature:</th>
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The colors of a traffic light will help you use your asthma medicines.

- **GREEN** means **Go Zone!** Use preventive medicine.
- **YELLOW** means **Caution Zone!** Add quick-relief medicine.
- **RED** means **Danger Zone!** Get help from a doctor.

## Go

You have **all of these**:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Use these daily preventive anti-inflammatory medicines:

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH</th>
<th>HOW OFTEN/WHEN</th>
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</table>

For asthma with exercise, take:

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH</th>
<th>HOW OFTEN/WHEN</th>
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## Caution

Continue with green zone medicine and add:

You have **any of these**:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH</th>
<th>HOW OFTEN/WHEN</th>
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CALL YOUR PRIMARY CARE PROVIDER.

## Danger

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Ribs show
- Can't talk well

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH</th>
<th>HOW OFTEN/WHEN</th>
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GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. **DO NOT WAIT.** Make an appointment with your primary care provider within two days of an ER visit or hospitalization.
INDIVIDUAL PLAN OF CARE

Please note: Project O has separate Epi-Pen and Asthma/Inhaler Plan of Care forms. This form is NOT required for Epi-Pens and Asthma/Inhalers

This form is required if a parent/guardian determines their child requires special care/accommodations while at camp. Health care needs such as allergies, special dietary needs, dental problems, hearing/visual impairments, chronic illness, developmental variations, etc. are examples that might require a Plan of Care.

NAME OF CAMPER ____________________________  Date of Birth ___/___/____

Special health care need/accommodation: ____________________________________________

_________________________________________________________________________

Please:

1. Explain the need for your child’s Individual Plan of Care (situations that warrant special care)
2. Outline the actions necessary for appropriate care of your child in the event of an emergency
3. Other relevant information (precautions to be taken to prevent a medical or other emergency)

Physician signature is not required, however, this plan of care should be developed with the child’s health care provider. If you have questions, please call our office at 860.445.9007.

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SELF SIGN IN & OUT
RELEASE TO WALK or RIDE BIKE

I give permission for my child to ride their bike or walk to and/or from Project Oceanology summer camp. I will not be accompanying my child to or from camp each day.

Project Oceanology’s daily procedure for Walkers/Bikers:

● Parent(s) will be notified if the camper doesn’t arrive to camp for check-in or if they do not pass the daily health screening (if they don’t pass the health screening, the camper will have to go back home immediately or wait for a parent to pick them up)

● At the end of camp each day, the camper will sign themselves out of camp and Project O camp staff will record the time

● If parent(s) wants additional procedure to be established (ie, notification to parent that camper is leaving), please add that information below and be specific:

Additional information for Project O camp staff:
________________________________________________________________________________

I understand that once my child is released from the camp, he/she will no longer be supervised by Project O camp staff and therefore authorized pick-ups will not be verified. I recognize that once my child has signed themselves out of camp, Project Oceanology is no longer responsible for my child.

Campers may not remain at Project Oceanology once they have signed out of camp.

____________________________________________________________
CAMPER’S FIRST & LAST NAME

____________________________________________________________
PARENT’S NAME (PRINTED)

____________________________________________________________
PARENT’S SIGNATURE

____________________________________________________________
DATE