NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

2026 Camp Wilton Camper Application

We will not process applications missing the required documents.

- **Speak to your Care Manager if you are going to use self- direction. CAMP WILTON IS NOT A WAIVER FUNDED PROGRAM. Campers seeking to use waiver funds will need to pay the $275.00 camp fee prior to attending.** We do not have a DOH certificate.
- **A history/physical examination (must be full physical), completed by a licensed medical professional, is required.** The exam must be within 12 months of attendance of the session to be attended. Attach a copy of the Progress Notes, if applicable. **Must include a current list of medical diagnosis, med orders, med lists, diet lists.**
- **If the camper is waiting to get an updated physical exam, please include a copy of the 2025 or most recent exam available so we can process the application and send the new exam prior to camp**. Please include physician orders, medications, diet, and treatments.
- **Campers are not accepted until they receive a confirmation packet for a specific session.** The packet is sent to the address indicated in the camper personal information section. Please make sure that we have complete phone numbers, email and postal addresses, including zip codes, for sending acceptance letters and camper evaluations.
- **Please provide the name, phone number (including area code) and email address of the care/service coordinator for communication.**
- We cannot accept ANY emailed or faxed applications or documents. Please send to the Corinth address listed below for processing.
- Our cabins are not air conditioned and there is very limited air-conditioned space on the grounds. If the individual has temperature restrictions for 90 °and above, we will not be able to accept the camper.
- We cannot accept campers that require bed checks more than hourly. If the camper lives in a residence that requires bed checks more than every hour and it is not to address a specific concern, a Treatment Team Leader or Administrator must provide a letter that indicates hourly bed checks are acceptable while the individual is at camp.
- **We are unable to support campers that require a bed alarm, open wounds, or those with or who receive nutrition via tube or other intense medical needs.**
- **Please complete ALL application fields, if not applicable please indicate such.**
- Send the application, postmarked by April 6th, to:
  Capitol District DDSO,
  Camp Wilton,
  200 Smith Drive
  Corinth, NY 12822

For more information:
Visit opwdd.ny.gov and search for “Camp Wilton” or Email: Camp.Wilton@opwdd.ny.gov

Camp Wilton 2026 Application

☑	REQUIRED DOCUMENTS:
	$275 CAMP FEE (NOTE**. Camp Wilton is not a waiver funded program**. **Campers seeking to use self-direction funds to pay for camp must speak to their Care Manager to determine if these funds can be utilized.**
	LP LIFE PLAN (include narrative from most recent annual plan)
	SSP SAFEGUARD Summary Plan
	BSP: RISK MANAGEMENT OR BEHAVIOR PLAN
	CURRENT NURSING ASSESSMENT (For campers living in state or voluntary residences)
	CURRENT DIET ORDER
	CURRENT HISTORY and PHYSICAL EXAM (Exam within the last 12 months)
	SIGNED PARENT/GUARDIAN CONSENT FORM
	RECENT CLEAR PHOTO OF CAMPER- (used for medication administration).
	DOCUMENTATION of ALL INOCULATIONS AND IMMUNIZATIONS
	MEDICATION LIST OR COMPLETED MAR
	CURRENT PHYSICIAN'S ORDERS

Please send all these documents with the fully completed camp application. Incomplete applications will result in a delay of a camper being accepted.

SESSION SCHEDULE

Session	Date	Details
1	June 22-26	Adults with Little or No need for Support
2	June 29-July 3	Adults with Moderate need for Support
3	July 6-10	Seniors Week
4	July 13-17	Adults with a High/ Moderate Need for Support
5	July 20-24	Adults with PWS
6	July 27-31	Adults with High need for Support
7	August 3-7	Adults with Moderate need for Support
8	August 10-14	Adults with Little or No need for Support

2026 CAMPER INFORMATION

CAMPER NAME:_____ Phone:( )_____

SESSION NUMBER PREFERRED: 1 2 3 4 5 6 7 8

ADDRESS (*street/city/state/zip*):_____

Age: _____ Date of Birth: _____ Gender: ☐ M ☐ F ☐ X **T-Shirt size:** _____

CAMPER HEIGHT:_____ **CURRENT WEIGHT:** _____

How will the camp fee be paid? **(No combined payments- 1 check per camper)** ☐Check ☐ Money order ☐ PA Funds **(DDSO's only)**

Camper Lives at: ☐ SOIRA ☐ VOCR ☐ VOIRA ☐ Family Care ☐ Home ☐ Independent Living

Catchment Area: (please check one of the following):

☐ Capitol District ☐ Sunmount ☐ Valley Ridge ☐ Taconic ☐ Long Island

☐ Central DDSO ☐ Staten Island ☐ Brooklyn ☐ Metro NY ☐ Finger Lakes

☐ Western NY ☐ Bernard Fineson ☐ Hudson Valley ☐ Broome

Person completing the application:

Name: _____ Relationship to Camper:_____

Address (☐ same as camper):_____

Phone Number (☐ same as camper): ( )_____ Alt. Phone: ( )_____

Email:_____ Fax Number: ( )_____

Caregiver Name (if different from above):_____ Email:_____

Phone Number (if different from camper): ( )_____ Alt. Phone: ( )_____

Service Coordinator: _____ Email:_____

Phone Number: ( )_____ Alt. Phone: ( )_____

INSURANCE

A COPY OF THE CAMPER'S INSURANCE CARD WILL BE REQUIRED AT CHECK IN

Does this camper currently receive **MEDICAID?** ☐ YES ☐ NO

MEDICAID #:_____ TABS ID#:_____

Does this camper currently receive **MEDICARE?** ☐ YES ☐ NO

MEDICARE #:_____

Other insurance plan and number? _____

OPWDD Eligible? ☐ YES ☐ NO Waiver Enrolled? ☐ YES ☐ NO

CAMPING EXPERIENCE

Is this the camper's first time attending Camp Wilton? ☐ YES ☐ NO Years of attendance:_____

Has the camper ever attended a different camp? ☐ YES ☐ NO ☐ Day ☐ Overnight.

Did the camper enjoy the experience(s) and adjust well? ☐ YES ☐ NO Details:_____

What were the camper's favorite things about camp?_____

What were the camper's least favorite things about camp?_____

Does the camper have strong fears (e.g. darkness, water, thunder, bugs, animals, crowds)? ☐ YES ☐ NO

Details:_____

What methods should be used to address these fears?_____

How does the camper react when upset, homesick or frustrated? What methods should be used to address these behaviors?_____

Is there any further information not otherwise stated in this application that may be helpful in better understanding the camper and his/her needs at camp?

_____

Does the camper require 1:1 supervision? ☐ YES ☐ NO Details:_____

What level of supervision does the camper need while in a camp or community environment (lots of people, open spaces)?_____

Is there any additional assistance the camper may require while at camp?_____

_____

GENERAL MEDICAL INFORMATION

BRACES, SPLINTS & ADAPTIVE EQUIPMENT: please list, ***MUST BRING TO CAMP:***

_____

COMMUNICATION (check all that apply)

☐ Verbal and can be clearly understood by others.
☐ Verbal but may be difficult to understand.
☐ Uses communication board/device.
☐ Other: _____
☐ Non-verbal
☐ Gestures
☐ Uses sign language

ACTIVITIES OF DAILY LIVING

SLEEPING CONCERNS

In what position does the camper prefer to sleep during the night? _____

_____

What assistance does this individual require for positioning during the night? _____

_____

Equipment: ☐ Side rails ☐ Pillows ☐ Wedge Size of Wedge: _____

Level of supervision necessary while in this position:_____

Please note: Two staff members sleep in each cabin nightly and are responsible for routine bathroom trips and assistance. We cannot accommodate campers who require consistent and frequent assistance throughout the night. **We cannot accept campers who require bed checks more often than every hour or who require a bed alarm.**

Does the camper generally sleep well? Normal sleeping hours:_____ ☐ **YES** ☐ **NO**

Does the camper require bedrails, a bed alarm OR a special mattress? ☐ **YES** ☐ **NO**

Alarm, Rails or mattress type: _____

Is the camper capable of sleeping on a top bunk? ☐ **YES** ☐ **NO**

IF THE CAMPER'S RESIDENCE REQUIRES A 30 MINUTE BED CHECK, A WRITTEN APPROVAL FOR HOURLY CHECKS FROM THE TREATMENT TEAM LEADER MUST BE PROVIDED WITH APPLICATION.

Does the camper require more than hourly bed checks? ☐ **YES** ☐ **NO**

If the individual requires more than hourly checks, please indicate reason:

SELF-CARE

Activity	Independent	Verbal Reminders	Physical Assistance	Total Support	Details including adaptive equipment needed
Dressing	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	
Oral Care	☐	☐	☐	☐	Wears dentures? ☐ Yes ☐ No Uses: ☐ Toothbrush ☐ Mouth Swabs/Toothettes ☐ Mouth Wash
Toileting	☐	☐	☐	☐	Toilet arms ☐ YES ☐ NO
Showering	☐	☐	☐	☐	***Uses a shower chair?*** ☐ ***YES*** ☐ ***NO***

How does the camper indicate they need to use the bathroom?

Is the camper incontinent at night? ☐ YES ☐ NO Details:

Is there a schedule for toileting? ☐ YES ☐ NO Schedule:

Activity	Independent	Verbal Reminders	Physical Assistance	Total Support	Details including adaptive equipment needed
Does the camper use the following? ☐ Urinal ☐ Bedpan ☐ Commode					
Wears incontinence product (Attends)? ☐ Night ☐ Day ☐ Not required					
Help with menstruation cycle? ☐ YES ☐ NO ☐ NA _____ Help required: _____ Comments/other: _____					

DINING

ATTACH A CURRENT DIET ORDER *AND* COMPLETE THE APPROPRIATE SECTION BELOW

FOOD CONSISTENCY

☐ **Puree**	Food is prepared using a food processor until smooth for an applesauce-like or pudding consistency.
☐ **Ground**	Food is prepared using a food processor until moist, cohesive and no larger than a grain of rice.
☐ **¼" Pieces Cut to Size**	Food is cut with a knife or chopped in a food processor into ¼-inch pieces.
☐ **½" Pieces Cut to Size**	Food is cut with a knife or chopped in a food processor into ½-inch pieces.
☐ **1" Pieces Cut to Size**	Food is served as prepared and cut by staff into 1-inch pieces.
☐ **Whole**	Food is served as prepared, no changes in preparation or consistency.

BEVERAGE CONSISTENCY: *if camper requires thickened beverages, they must bring thickener.*

☐ **Thin Liquid**	Liquids are served without change.
☐ **Nectar Thick Liquid**	Thickened liquid that flows from the spoon in one steady stream; same consistency of the heavy syrup found in canned fruit, or maple syrup.
☐ **Honey Thick Liquid**	Thickened liquid that flows slowly from the spoon but still pours; same consistency of table honey in squeeze bottle containers.
☐ **Pudding Thick Liquid**	Thickened liquid that does not pour from the spoon; the spoon stands up in the product and requires a spoon for eating.

DIET SPECIFICATIONS

☐ **Calories** _____

☐ **Diabetic** ☐ **Low Fat/Cholesterol** ☐ **High Fiber** ☐ **GERD** ☐ **Gluten Free** ☐ **Lactose Intolerant**

☐ **Other Diet Modification** _____

Nutrition Supplements & Frequency (nutritional drinks, puddings, powders, etc)

_____

☐ **Fluid Restriction** _____

☐ **Increased Fluids** _____

ADAPTIVE EQUIPMENT MUST BE BROUGHT TO CAMP

☐ **High Need**	Requires ongoing monitoring due to health concerns and swallowing requires specific training of techniques
☐ **Consistent**	Ranges from providing minimal prompts to needing direct assistance to dine.
☐ **Supervised**	May require assistance with set-up, cut-up and/or clean-up.
☐ **Independent**	Requires no supervision during dining/training protocol

FOOD PACING, PORTIONING & ADAPTIVE EQUIPMENT:

Portion Size: ☐ 1 spoonful ☐ 2-3 bites ☐ half of meal ☐ all of meal

Utensil: ☐ Regular ☐ Teflon-coated spoon ☐ Plastic spoon ☐ infant or small/fork spoon
☐ Spoon/fork with built-up handle ☐ Curved spoon **[** ☐ right ☐ left**]** ☐ Other: _____

Dish: ☐ Regular ☐ High sided dish ☐ Scoop dish ☐ Inner lip plate ☐ Dycem

BEVERAGE SET-UP – PORTIONING/ADAPTIVE EQUIPMENT

Portion Size: ☐ Single Sip ☐ Multiple Sips ☐ Spoon Fed ☐ Other:_____

Cup:
☐ Cut-out cup ☐ Sippy cup ☐ Cup with built-in straw ☐ Handled mug
☐ Regular ☐ with disposable straw ☐ no straw Other:_____

DINING POSITION (Note the positioning for the individual and the dining assistant.)

☐ No special positioning needs for dining ☐ Needs armed chair
☐ Individual sits in a wheelchair at the table (specifications):_____
☐ Dining assistant positioning:_____

☐ Additional details:_____

BEHAVIORAL PROFILE

So we can best prepare for and meet the needs of the camper, please provide accurate and detailed information as well as a current behavior plan, if available. Include behaviors displayed at home, at school/program and in the community.

Behavior	Never	Seldom	Often	Explain/Details
Enjoys social gatherings	☐	☐	☐	
Interacts with peers	☐	☐	☐	
Follows directions	☐	☐	☐	
Destructive	☐	☐	☐	
Emotional outbreaks	☐	☐	☐	
Lying	☐	☐	☐	
Stealing	☐	☐	☐	
Physically aggressive	☐	☐	☐	
PICA	☐	☐	☐	

Behavior	Never	Seldom	Often	Explain/Details
Scratches, hits or grabs	☐	☐	☐	
Self-abuse	☐	☐	☐	
Self-stimulating behaviors	☐	☐	☐	
Sensitive to touch	☐	☐	☐	
Temper tantrums	☐	☐	☐	
Uses inappropriate language	☐	☐	☐	
Wanders or runs away intentionally	☐	☐	☐	
Wanders unintentionally due to distractions	☐	☐	☐	
What approaches are most effective to help camper de-escalate or calm?				
Are there any preferred activities?				

TRANSFERS/POSITIONING/MOBILITY

ATTACH A CURRENT MOBILITY FACT SHEET *AND* COMPLETE THE APPROPRIATE SECTION

AMBULATION – LEVEL OF ASSISTANCE

☐ **INDEPENDENT** with all ambulation ☐ Walks with **DIRECT STAFF SUPPORT**

☐ Requires **ASSISTIVE DEVICE** for ambulation (cane, crutches, walker, etc.) Device:_____

Comments:_____

WHEELCHAIR MOBILITY – LEVEL OF ASSISTANCE;

PLEASE NOTE: Many areas of camp have uneven surfaces or a distance between activities. If the camper uses a wheelchair for these situations, the chair and footrests should come with them to camp.

Type of wheelchair: ☐ *Manual* ☐ *Power*

When? ☐ *For long distances ONLY* ☐ *At all times*

Does the camper self-propel? ☐ *YES* ☐ *NO*

TRANSFERS: there are mechanical lifts available at camp

☐ *Independent*

☐ *Mechanical lift (with sling)* ☐ *Two-person lift* ☐ *One-person lift*

☐ *Stand-pivot transfer* ☐ *Sliding board transfer*

☐ *Alternative transfer (specify):* _____

Comments: _____

POSITIONING

Check all that apply.

The individual is **Independent** with: ☐ In-wheelchair positioning ☐ Out-of-wheelchair positioning

The individual is **Dependent** with: ☐ In-wheelchair positioning ☐ Out-of-wheelchair positioning

DAILY POSITIONING/RE-POSITIONING

What assistance does this individual require for positioning/repositioning during the day? _____

_____

_____

Frequency of out-of-chair repositioning:_____ Length of time:_____

Equipment: ☐ Floor mat ☐ Bed ☐ Wedge ☐ Pillows

Level of supervision necessary while in this position:_____

MEDICAL INFORMATION

****

THIS SECTION MUST BE FULLY COMPLETED FOR CAMPER TO BE ACCEPTED

Nursing is a critical component of camp operations. Please follow instructions as they are written. Failure to follow these instructions may result in the camper not being accepted or they may be sent home.

****

Camper Name: _____ DOB:_____

Home Phone: ( )_____ Alternate phone: ( )_____

Person to contact for Medical Consent

Individual/Self Consenting Yes ☐

Name:_____ Relationship to Camper: _____

Phone Number: ( )_____Alternate Phone Number: ( )_____

Alternate contacts in the event of an emergency, illness or injury

List individuals granted permission to pick up the camper at any time during the camper's session. Please inform the individual(s) prior to the camp session that they have been listed as a contact. Camp management will release the camper only to individuals listed below.

Name: _____ Relationship to Camper: _____

Phone Number: ( )_____ Alternate Phone Number: ( )_____

Name: _____ Relationship to Camper: _____

Phone Number: ( )_____

Alternate Phone Number: ( )_____ CODE Status_____

Primary Physician:_____ Phone Number: ( )_____

Address:_____

Provide copy of doctor's note from the camper's annual physical exam.

Residential/House Nurse _____Phone Number: ( )_____

Email:_____

DIAGNOSIS (Please list or provide a printed list)

Does the patient have an acute or chronic wound? ☐ Yes

We may not be able to support campers with wounds.

If yes please describe the wound and it's treatment:

IMMUNIZATIONS (Give dates of all inoculations *AND* attach a copy of the vaccination record.)

Hepatitis B Immune ☐ Positive Carrier ☐ Unvaccinated negative for carrier status ☐ Unknown Has the camper had the **Hep B Vaccination Series**? Yes ☐ **Please provide lab work indicating the camper's Heb B Antibody status, if available.**	
Tetanus: include documentation	Date of most recent Tetanus shot:
Varicella (Chicken Pox) Disease or vaccination (please circle choice)	Dates:
Immunization for COVID	Date of last COVID-19 vaccine/booster: Has camper had COVID? Yes ☐ If so, when?

ALLERGIES

List all food, MEDICATION, and/or environmental allergies. Please note any severe reactions.		
Does the camper use an Epi-Pen?	Yes ☐	If yes, why:

How are medications taken?	Whole ☐	Crushed ☐	Medications taken with: Liquids ☐ Applesauce ☐ Pudding ☐ Other ☐
Does the camper require thickened liquids?	Yes ☐	If yes indicate: Nectar ☐ Pudding ☐ Honey ☐	
Lactose intolerant?	Yes ☐	Specify if taking lactaid or absorption aid.	

B.M. HISTORY:

If camper is independent with toileting, bowel movements are not tracked and they have no history of constipation, to ensure dignity, the camp nursing staff will not provide follow-up unless the camper complains of discomfort or presents discomfort with constipation.		
Does the camper have issues with bowel movements or a history of constipation?	Yes ☐	If yes, what medications are given for constipation: _____ on day # _____ of no B.M.

DIABETES: ☐ Yes If yes, please respond below:

How is it controlled: ☐ Diet ☐ Oral Medication ☐ Insulin

What are the signs/symptoms when low? _____

What are the signs/symptoms when high? _____

Blood sugar testing? ☐ Yes If yes, _____times per day.

Method: ☐ Finger stick ☐ Continuous Glucose monitoring/ Patch Libre/Dexcom

Is Low Blood sugar a frequent issue? ☐ Yes

TEMPERATURE RESTRICTIONS? ☐ Yes

If yes, please indicate what temperature below/above to limit outside activity: _____

SEIZURE ACTIVITY

Does the camper have a seizure disorder? ☐ ***Yes***

If so, please include their seizure action plan or plan of care.

How often? ☐ ***Daily*** ☐ ***Weekly*** ☐ ***Monthly*** ☐ ***Controlled by medication***

Date of last seizure: _____

Does the camper have any auras? Describe:

_____

Describe type, duration, characteristics, known triggers, etc._____

Does the camper use Vagus Nerve Stimulation (VNS)? ☐ Yes

ASTHMA & OTHER RESPIRATORY ISSUES

Does the camper have asthma or respiratory issues? ☐ ***Yes*** ***If yes, please respond below and include action plan or plan of care:***

Describe frequency & character of issues/attacks:

Sensitivity to humidity? ☐ Yes

Any activity limitations

Does the camper use oxygen? ☐ *Yes If yes, we will be unable to support them.*

FALL RISK YES ☐

If yes, please include the plan of care.

OSTEOPOROSIS OR OSTEOPENIA Yes ☐

If yes, please include the plan of care.

SLEEP APNEA

Does the camper have sleep apnea? ☐ Yes If yes, please respond below:

Do they use C-Pap or Bi-Pap machine? ☐ YES

If yes, camper will need to bring machine, tubing, mask and distilled water.

Any activity limitations?

☐ This individual WILL NOT TAKE any routine medications while attending camp.

☐ This individual WILL TAKE routine medications while attending camp. If yes, see directions below.

One or both of the following should be completed.

1. **Provide signed doctor's orders for medication. Update required the week before camper is to attend camp.**
2. **Complete included camp Medication Administration Record (MAR) and have the camper's primary care physician sign. Update required the week before camper is to attend camp.**

CAMPER NAME: _____DOB_____ Cabin # _____

(If needed) Physician Signature: ***Name:*** ***Date:***

MEDICATION ADMINISTRATION RECORD

Takes Meds:_____Last BM: _____

CODES **H** = HOSPITAL **R** = REFUSED	ALLERGIES:	Date					
		Dates					
Camp Staff Only **Bottle#**	**# of Pills**	**Medication, Pills, Liquids, Drops, Powders, other**	TIME	M	T	W	T	F
		Med: _____ **Directions: _____**						
		Med: _____ **Directions: _____**						
		Med: _____ **Directions: _____**						
		Med: _____ **Directions: _____**						
		Med: _____ **Directions: _____**						

Capital District DDSO Standing Orders

Name:_____ DOB:_____ Residence:_____

ALLERGIES:
A Registered Nurse MUST be contacted PRIOR to administration of ANY of the following medications, and none can be administered more than 2 days without additional orders (exceptions for Sunscreen, insect repellent). May administer Acetaminophen (Tylenol) for fever as indicated below and call RN after.
☐ **ACETAMINOPHEN: (Tylenol):** _____mg PO, PT or PR (Suppository) every **4 hours as needed (PRN)** for Oral, Temporal, Tympanic temperature above 100.5 F OR a rectal temperature above 101.0 F OR PRN for signs/symptoms of general discomfort. **[MDD 3 Grams (3,000mg) in 24 hours]**
☐ **IBUPROFEN: (Advil or Motrin):** _____ mg PO, PT every **4 hours PRN** for symptoms of arthritis pain, headache, toothache, muscle/joint pain **[MDD 3.2 Grams (3200mg) in 24 hours]** (If patient is known to have a history of kidney disease, bleeding ulcers or is on blood thinners or other NSAIDS **do not include** this order in the standing order)
☐ **ALUMINUM-MAGNESIUM HYDROXIDE w/ simethicone (Mylanta or Maalox plus):** 30 ml PO or PT every **6 hours** PRN for minor stomach upset or indigestion. **(MDD 4 doses in 24 hours)**
☐ **GUAIFENESIN WITH DEXTROMETHOPHAN *SUGAR FREE* DM (Regular strength Robitussin DM*SUGAR FREE*):** 20 ml **(20mg dextromethophan/200mg guaifenesin)** PO or PT **every 4 hours PRN** for minor cough without fever **(MDD 120ml in 24 hours)**
☐ **MAGNESIUM HYDROXIDE** *IN WATER* **(Milk of Magnesia):** 30 ml PO or PT for no bowel movement in 72 hours/3 days/9 shifts. Drink with full 8 oz. glass of liquid. **(MDD 60 ml in 24 hours)** ****DO NOT USE IF SYMPTOMS OF ABDOMINAL PAIN, RECTAL BLEEDING, NAUSEA OR VOMITING ARE NOTED****
☐ **BISACODYL SUPPOSITORY (Dulcolax): 10 mg** PR (suppository) for no bowel movement if MOM (given day 3 no BM) ineffective after 24 hours **(MDD 10mg PR in 24 hours)** ****DO NOT USE IF SYMPTOMS OF ABDOMINAL PAIN, RECTAL BLEEDING, NAUSEA OR VOMITING ARE NOTED****
☐ **ZINC OXIDE TOPICAL CREAM (Destin):** Apply thin layer topically as needed to clean dry skin to prevent/treat moisture rash. Apply during pericare/toileting/hygiene PRN ☐ **CALMOSEPTINE (Risamine):** Apply thin layer topically as needed to clean dry skin to prevent/treat moisture rash/Skin breakdown. Apply to affected area BID and PRN if wipes off. Remove with mineral/baby oil
☐ **HYDROCORTISONE CREAM 1%:** Clean affected area with soap and water, then pat dry. Apply topically **PRN every 6 hours** for itchy skin or rash **(MDD 3 applications unless provider specifies alternate frequency)**
☐ **BACITRACIN 500u/gram:** Clean affected area with soap and water, then dry. Apply topically **TID and PRN per nurse direction** for superficial abrasions
☐ **NEW SKIN LIQUID BANDAGE 1%:** Clean affected area with soap and water, then dry. Spray/apply a small amount on the area and let dry **Per nurse direction up to 3 times/day and PRN when removed** for superficial abrasions
☐ **SUNBLOCK SPF 50 or higher:** Apply topically to all exposed skin 30 minutes prior to sun exposure. **Re-apply every 90 minutes** for continuous sun exposure, after swimming, toweling or excessive sweating.
☐ **INSECT REPELLENT:** Apply to exposed skin and clothing prior to outdoor activity. **Repeat after 8 hours** as needed (early spring through late fall) **(MDD=2 applications in 24 hours)**
☐ **HOLD STOOL SOFTENERS AND/OR LAXATIVES FOR UP TO 48 HOURS** for loose stools, **MUST NOTIFY RN FIRST.** (Examples of stool softeners/laxatives: Colace, Senokot, Dulcolax, MOM, Miralax, Amitza, Sorbitol, Citrate of Mag)
☐ **LOPERAMIDE (Imodium A-D): 4mg** PO or PT initially, followed by **2 mg** PO or PT after each subsequent loose stool (30 minutes in between doses-**MDD 16mg in 24 hours)** **MUST NOTIFY RN** before administration of each dose
☐ **DIPHENHYDRAMINE (Benadryl): 25 mg** PO or PT every **6 hours PRN** for temporary relief from symptoms due to hay fever or other allergy symptoms, itchy watery eyes, insect bites, minor rash **(MDD 300mg in 24 hours)**
☐ **PHENYLEPHRINE (Sudaphed PE):** 30 MG PO or PT **PRN every 6 hours** for nasal congestion **(MDD 240mg in 24 hours)**
☐ **Individual is cleared to swim with supervision (only after swim evaluation)**

Providers Signature:_____ Date:_____

Medical Policy Section #306, Revised 12/2024 (Standing order valid for 1 year)

CAMPER NAME: _____

CAMP WILTON CONSENT

☐ **CONSENT TO TREAT**

In the event of an emergency wherein any of the documented physicians are not available, I give my consent to provide treatment and to conduct any tests by appropriate medical staff on duty that are required to intervene and obtain necessary medical care.

☐ **CONSENT TO ATTEND AND PARTICIPATE**

I hereby request and give permission to the New York State Office for Developmental Disabilities permission for the named camper to attend Camp Wilton and participate in all activities. I also agree not to send this individual to Camp if exposed to a contagious disease within 21 days of the date the applicant is to report to Camp, and I will notify the Camp Director immediately.

MEDICATION AUTHORIZATION (check one)

☐ NO The below named camper does not need to take any routine medication (prescription or over-the-counter) while at camp.

☐ YES The below named camper will need to take medication while at camp. I authorize administration of the prescribed medications.

PERMISSION TO APPLY SUNSCREEN AND BUG SPRAY

I give the staff at Camp Wilton permission to apply the following to the below named camper.

☐ Sunscreen

☐ Bug Repellent

PHOTO RELEASE (check one)

☐ Permission is given to Camp Wilton and OPWDD to use any photograph, digital or video taping of the camper and the camper's name for television news stories, newspaper articles, news releases, publications (brochures, newsletters, website, etc.) and community awareness programs.

☐ Permission is not given

WAIVER

All the information provided is accurate and complete to the best of my knowledge.

As the Parent/Guardian/Advocate of_____, I have read and understand the above.
Camper Name

_____ _____
Parent/Guardian/Advocate Signature **Date**

_____
Relationship to camper

CAMPER NAME: _____

SWIMMING INFORMATION

Swim assessments will be done at camp by our Red Cross certified lifeguards. Assessments will be sent home with the camper at the end of the session.

Does the camper enjoy swimming? ☐ YES ☐ NO

Will the camper swim at camp? ☐ YES ☐ NO

If the camper does not enjoy swimming, will they want to be at the pool during swim time?

☐ YES ☐ NO

Will the camper enjoy dipping their feet in the water? ☐ YES ☐ NO

Does the camper wear ear plugs when in the pool? ☐ YES ☐ NO

Are there any swimming restrictions? ☐ YES ☐ NO Details:_____

_____

As the Parent/Guardian/Advocate of_____, I have read and understand the above.
Camper Name

_____ _____

Parent/Guardian/Advocate Signature Date