SEM
BUFFALO SEMINARY
EST. 1851

Summer at SEM Health and Permissions Form – Day Camper

Please upload on Campium,email or fax forms before camper starts. Forms could be emailed to: mainoffice@buffaloseminary.org or faxed to (716)885-6785.

Each camper is required to submit a health appraisal and vaccination form, valid within the year, from their physician or complete the SEM Health Appraisal form prior to attending camp.

Emergency Contact Information:

Camper Name:	Date of Birth:
Primary Emergency Contact Person:	
Relationship to Camper:	
Phone #:	Alternate Phone #:
Another Person to Contact:	Phone #:
Name of Doctor:	Phone #:

Please answer the following questions:

1. Does the camper have any restrictions to physical activity? If, yes, explain:

2. Does the camper have any medical conditions we should know about such as asthma, allergies (including food allergies), etc.?

3. Does the camper require any medication to be self-administered or administered by a camp staffer during camp hours such as Tylenol, Motrin, inhaler, epi-pen, etc.? If YES, please note condition below and provide written information for administration of prescription or over-the-counter medication from your health care provider.

Permission for Emergency Medical Treatment:

In the event of an emergency requiring medical attention, every effort will be made to contact the parent/guardian in order to receive authorization before any treatment or hospitalization is undertaken. I hereby authorize and consent to the Camp Director or designated representative in charge, present with my child, to act in accordance with his or her judgment to seek appropriate care for my child with a licensed physician, nurse or emergency personnel for treatment. This representative is absolved from any liability or financial responsibility in connection herewith.

Camper Name:	
Parent/Guardian Name:	
Signature:	Date:

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Permission to Ride in Camp Vehicles:

A camp bus may be used to transport campers and staff to and from off-site camp events. I give my permission for my child to ride in these vehicles. I understand that there are normal risks of travel and participation in this activity and as a parent or guardian, hereby assume the risk of any injury to my child however caused and whether by negligence or otherwise.

Camper Name:

Parent/Guardian Name:

Signature: Date:

Parent/Guardian Agreement to the Use of Photos and Videos of Students:

Buffalo Seminary reserves the right to use video footage and/or photographs of my child. The video footage and/or photographs will be the property of the school. Rights to these materials are waived, including the right to inspect and/or approve copy that may be used in conjunction with uses to which they may be applied. The pictures and/or video footage may be used as Buffalo Seminary sees fit for the production of educational or promotional materials and any other lawful purpose. We will use only images (video and still photography) that reflect positively on the student and the school.

Media Opt Out:

☐ I do not give Buffalo Seminary the right to use video footage and/or photographs of my child.

Student Name:

Parent/Guardian Name:

Signature: Date:

Please address any questions to mainoffice@buffaloseminary.org

SEM BUFFALO SEMINARY
Buffalo Seminary Health Examination Form
205 Bidwell Parkway, Buffalo NY 14222 Phone: (716)885-6780 FAX: (716)885-6785

NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: Buffalo Seminary requires a physical exam annually for all students and annually for interscholastic sports.

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results:_____Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

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Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V ☐

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please return this form to, Alex Skomra, Camp Director when completed.

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Buffalo Seminary Summer at SEM Emergency Contact & Permissions Form

This form must be submitted each year. Please return Permissions and Health Appraisal forms by your daughter's first day of camp. Forms can be mailed to Buffalo Seminary, 205 Bidwell Parkway, Buffalo, NY 14222, faxed to (716)885-6785, or emailed to Alex Skomra at askomra@buffaloseminary.org.

Emergency Contact Information

Student Name:	Date of Birth:	Class of:
Parent/Guardian 1 Name:	Relationship:	
Phone number:		
Email:		
Address:		
Parent/Guardian 2 Name:	Relationship:	
Phone number:		
Email:		
Address:		

Permission for Emergency Medical Treatment:

In the event of an emergency requiring medical attention, I hereby authorize and consent to the designated responsible Buffalo Seminary representative in charge, present with my daughter, to act in accordance with his or her judgment to seek appropriate care for my daughter with a licensed physician, nurse or emergency personnel for treatment. This representative is absolved from any liability or financial responsibility in connection herewith.

Permission for Over-the-Counter (OTC) Medication Administration:
To receive stock OTC medication, a completed Buffalo Seminary Provider and Parent Permission to Administer Medication form must be on file with the Nurse.

Please indicate any allergies, medication allergies or special medical conditions and recommended treatment:

Parent/Guardian Name:	Date:
Signature:	

For Office Use Only

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Buffalo Seminary Provider and Parent Permission to Administer Medication

This form must be submitted each year. Please return completed form your daughter's first day of camp. Forms can be mailed to Buffalo Seminary, 205 Bidwell Parkway, Buffalo, NY 14222, faxed to (716)885-6785, or emailed to Alex Skomra at askomra@buffaloseminary.org.

All students must have patient specific orders from their provider for any prescription and over the counter (OTC) medication along with written parent/guardian consent for such medications to be administered to, or taken by their child, including school stock OTC. Parent/guardian consent must specify permitting administration of stock medication. These medications include, pain reliever, fever reducer, anti-inflammatory, antihistamine, decongestant, antacid, topical applications, cough drops, and sunscreen.

To be completed by parent or guardian:

I authorize the school health staff to give my child the following prescription or OTC medication as prescribed by our licensed health care provider. After the school nurse determines that my child can take their own medications, other trained staff may assist my child to take their own medications. Prescription medication will be provided by me in the properly labeled original container from the pharmacy. OTC may be given from health office stock supplies ONLY if written authorization is given by the student's parent/guardian or health care provider.

Student Name:	Date of Birth:	Class of:
Parent/Guardian Name:	Relationship:	
Phone where we can reach you:	Email:	
Signature:	Date:	

To be completed by licensed health care provider – VALID FOR 1 YEAR

Diagnosis:

Medication(s), dosage, frequency, route, and times, to be taken during the school day:

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.

The school nurse has my permission to administer the following OTC medication to my patient (provide dosage):

_____Acetaminophen	_____antacid	_____topical
_____Ibuprofen	_____cough drops	
_____Diphenhydramine	_____sunscreen	

☐ 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 in school. Check this box and complete the attestation to request this option.

Name/Title of Prescriber (Please Print):	
Prescriber's Signature:	Date:
Phone:	
Address:	

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Provider Attestation and Parent Permissions for Independent Medication Carry and Use

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 student 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 student 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: Date of Birth:

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 at any school/school sponsored activity. 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)

Name/Title of Prescriber (Please Print):

Prescriber's Signature: Date:

Phone:

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 at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Name:

Signature: Date:

BUFFALO SEMINARY SUMMER@SEM WELLNESS POLICY

This form must be completed and returned prior to your child attending camp.

Camper's Name _____ Date _____

Please review Buffalo Seminary's Summer@SEM wellness policy below and sign that you have read and agree to abide by it. If your child is not well, please call us to let us know. Some illnesses need to be reported to other families and the NYS Department of Health. If you or anyone in your household is under quarantine for COVID-19 your child must be excluded from camp. A wellness screening and temperature check will be conducted before a camper or counselor enters the building.

WELLNESS POLICY

We need every family's cooperation to provide a healthy environment for all the campers. Below are guidelines for you to follow when your child is ill. If your child's health is questionable, please keep them home.
If your child shows any of the following signs of illness, they MUST stay home:

FEVER: a child with a temperature at or above 100 degrees may not return to camp until they have fever-free for a full 72 hours without fever-reducing medication (i.e. fever on Monday, fever-free Tuesday-Thursday, may return to camp)
VOMITING and/or **DIARRHEA:** a child may not return to camp until they have been free of these symptoms for a full 24-hour period without medicine.
Suspicious **SKIN RASHES** or **LESIONS**
NASAL CONGESTION: thick, yellow/green discharge, interferes with breathing, not related to allergies
COUGH: persistent, dry, "croupy" or "barking"
IRRITABILITY
LISTLESS, no energy
POOR APPETITE associated with other signs
Complaining of a **SORE THROAT** or **EARACHE**

WHAT TO EXPECT IF YOUR CHILD BECOMES ILL WHILE ENROLLED AT CAMP

- If your child has a fever of 100, they MUST be kept at home until fever-free for a full 72 hours without medicine.
- If your child VOMITS or has DIARRHEA, they must be kept at home for a full 24 hours without symptoms or medicine.
- SKIN RASHES or LESIONS will require a doctor's note to return and must comply with Health Department recommendations.
- Allergy symptoms must be confirmed by a doctor.
- When you are called during the day because your child has become ill, arrangements must be made for your child to be picked up within 30 minutes.
- When your child returns to camp after an illness, the counselor will do a wellness screening and temperature check. If it appears that your child is not ready for a full day of camp, you will be asked to take your child home. The same policy applies to a child who appears to be getting ill. Your cooperation will enable us to keep illness at a minimum.

It is the parents'/guardians' responsibility to notify the Camp Director if their child has been exposed to any contagious illness including, but not limited to, coronavirus, chickenpox, strep throat, coxackie, lice, impetigo, and flu. This policy has been instituted to benefit our entire camp community.

I have read and agree to abide by the Buffalo Seminary Summer@SEM's wellness policy.

_____

Parent Name Parent Signature