

# CHENANGO COUNTY SHERIFF'S CAMP

## PARENT INFORMATION

[www.chenangosheriff.us](http://www.chenangosheriff.us)

**PARENTS:** Please keep pages 1 & 2 (Parent Information) of this packet. Pages 3, 4, & 5 (Sheriff's Camp Consent Form) need to be **completed in full** and returned to the Chenango County Sheriff's Office no later than the Friday of the week before your child is to attend camp.

**PROGRAM** - The Camp program runs Monday morning through Thursday afternoon and is for youths ages 9 years to 12 years. The bus leaves from the Sheriff's Office 279 Co Rt 46, Norwich (Road across from WalMart, past Lowe's, ½ mile up hill, facility on left) You must have your child/children at the Sheriff's Office by **8:00 am** on Monday for check in and they must be picked up by **5:00 pm** on Thursday from the Sheriff's Office.

**OPERATION SAFE CHILD** - [www.criminaljustice.state.ny.us](http://www.criminaljustice.state.ny.us) If you complete the top half of the attached form this program provides you with a safe child card containing your child's statistical information, fingerprint and photo. If you completed the entire form all the child's information will be filed in a database with DCJS making the information available statewide if an Amber Alert should ever become necessary.

**THE CAMP** - YMCA Camp Thompson is located on Rourke Rd off of Chenango County Route 16 in the Town of Smyrna. The Camp telephone number is **607-334-7568**.

**CAMP STAFF** - There will be a certified camp director appointed by the Sheriff. Sheriff Cutting and/or his staff will be available on the premises including medical personnel.

**WHAT TO BRING TO CAMP** - All campers should bring the following items:

Sleeping bag and/or 2 blankets with sheets	Heavy jacket/sweat shirt
Pillow	Sneakers (at least one pair)
Bug Repellent & Sun Screen	Long pants (jeans, sweats, winds)
T-shirts and shorts	Towels
Swimsuit	Shampoo
Underwear	Bar of soap
Socks	Comb/Brush
Toothbrush/Toothpaste	Sun Glasses
Rain coat/poncho	Flash light
Hat & baseball glove (optional)	

**ALL OF YOUR CHILD'S PROPERTY SHOULD BE LABELED WITH THEIR NAMES  
DO NOT SEND MONEY, CELL PHONES OR PAGERS TO CAMP WITH YOUR CHILD.**

### POLICIES AND PROCEDURES

**INJURY OR ILLNESS AT CAMP** - If your child is seriously injured or becomes ill, our staff will attempt to contact a parent or guardian. If unavailable, the Sheriff's Office will contact the people you list on the following emergency information form. If we cannot contact you or the people you list, we may call an ambulance or paramedic, or have our Road Patrol attempt to contact you at your home.

Keep this page

**MEDICATION** - If your child needs to take medication while at camp, Medication should be brought to check-in by the parent or guardian directly to the staff with written instructions specifying the quantity and times to be administered. The name and phone number of your doctor, and any other instructions must accompany the medication. Written clearance must be given to the Camp Staff (camp medical staff) to administer any medication. This includes all over-the-counter medications (Tylenol, aspirin, pain or cold or allergy medications etc.) as well as prescription medications. **The campers/children are not to have any medication in their possession**, for the safety of all the children attending.

**PICK UP / DROP OFF POLICY** - Only those authorized on your child's information form may pick up your child/children. The camp staff will not release your child into anyone else's care. **Children must be picked up by 5:00 pm on Thursday.**

**DISCIPLINE POLICY** - Camp Staff will implement our progressive discipline policy when behavior expectations are not met. Listed below are the steps utilized.

1. Verbal warning is given.
2. The child is given time to refocus and redirect
3. If behavior continues, the child will be dismissed from the program.

**HEALTH FORMS** - Upon registration, you must complete a Sheriff's Camp Consent Form. Children will not be allowed to attend camp until these forms are completed, which includes a immunization history form. Completion and submission of the application by parent is giving permission for their child to carry and use insect repellent and/or sunscreen. These items can be brought in by the camper or may be provided and applied by camp personnel.

**PERSONAL PROPERTY RESPONSIBILITIES** - It is understood that as the Parent(s) and/or Guardian(s), I am responsible for any lost or misplaced personal property my child brings to camp. ***UNCLAIMED ITEMS LEFT BEHIND AT THE CAMP WILL BE DONATED TO CHARITY ONE MONTH AFTER THE LAST DAY OF CAMP.***

**CAMP DATES:**  
07/08/19 through 07/11/19  
07/15/19 through 07/18/19  
07/22/19 through 07/25/19  
07/29/19 through 08/01/19

**SCHOOL DISTRICTS**  
Norwich, Oxford  
Sherburne-Earlville, Unadilla Valley  
Greene, Afton, Bainbridge-Guilford  
Gilbertsville-Mt. Upton & Otselic

**IF THERE ARE ANY QUESTIONS ABOUT THE CAMP  
PLEASE CONTACT**

**THE CIVIL DIVISION AT (607) 334-5175 Monday thru Friday, 8:30am to 5pm**

**THE CAMP IS FREE TO CHENANGO COUNTY CHILDREN. WE HAVE RAISED THE MONEY THROUGH DONATIONS FROM CHENANGO COUNTY BUSINESSES, INDIVIDUALS, AND ORGANIZATIONS. UNLESS YOU ARE CONTACTED OTHERWISE YOUR CHILD WILL BE ACCEPTED TO CAMP WHEN YOU SUBMIT THE APPLICATION**

**Mail Application to: Chenango County Sheriff's Office, 279 Co Rt 46, Norwich, NY 13815**

**Keep this page**

**PLEASE PRINT LEGIBLY**  
**SHERIFF'S CAMP CONSENT FORM**  
**Your child is accepted into camp when you submit the**  
**completed application unless you are contacted otherwise.**

NAME OF CHILD \_\_\_\_\_  
(Last) (First) (Middle)

**GENDER (CIRCLE ONE):** Male / Female : Age \_\_\_\_\_

<u>CAMP DATES:</u>	<u>SCHOOL DISTRICTS</u>
07/08/19 through 07/11/19	Norwich, Oxford
07/15/19 through 07/18/19	Sherburne-Earlville, Unadilla Valley
07/22/19 through 07/25/19	Greene, Afton, Bainbridge-Guilford
07/29/19 through 08/01/19	Gilbertsville-Mt. Upton & Otselic

By completing this form I agree that photos taken at summer camp may be used by the Sheriff's Office for display on their webpage, bulletin boards, camp advertising, and for any fund-raising efforts.

**email:** \_\_\_\_\_

ADDRESS \_\_\_\_\_

NICKNAME \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PARENTS' NAMES \_\_\_\_\_

PARENTS ADDRESS (if different) \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ NAME: \_\_\_\_\_

CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ NAME: \_\_\_\_\_

MOTHER'S WORK & SHIFT \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

FATHER'S WORK & SHIFT \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**IF NOT AVAILABLE, IN CASE OF EMERGENCY OR ILLNESS, PLEASE CALL:**

NAME \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*Complete & Return this page*

CHILD'S DOCTOR \_\_\_\_\_

PHONE: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

NAME OF INSURANCE COMPANY \_\_\_\_\_

INSURANCE IDENTIFICATION NUMBER \_\_\_\_\_

DOES YOUR CHILD HAVE ANY DISABILITIES OR MEDICAL PROBLEMS WE SHOULD BE AWARE OF? \_\_\_\_\_

IF YES EXPLAIN: \_\_\_\_\_

\_\_\_\_\_

DOES YOUR CHILD HAVE ANY ALLERGIES TO FOOD? \_\_\_\_\_

**PARENTS AUTHORIZATION**

IN THE EVENT THAT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE SHERIFF'S OFFICE TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO GIVE INJECTION, ANESTHESIA, OR SURGERY FOR MY CHILD NAMED ABOVE.

I have read and understand the information regarding the Sheriff's Summer Camp Program.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / 19 \_\_\_\_

Parent/Guardian Name \_\_\_\_\_

(please print legibly)

Child's Name \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / 19 \_\_\_\_

**If you are not able to pick your child after camp from the Sheriff's Office, please complete the section below:**

I, \_\_\_\_\_, authorize \_\_\_\_\_

to pick up my child \_\_\_\_\_ from Sheriff's Summer Camp on

\_\_\_\_ / \_\_\_\_ / 19 \_\_\_\_.

Complete & Return this page

# IMMUNIZATION HISTORY (COPIES OF SHOT RECORD ACCEPTABLE)

Child's Name: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

Physician: \_\_\_\_\_

Diphtheria Tetanus Pertussis	TYPE OF VACCINE	DATE GIVEN		NAME/TITLE OF PERSON/CLINIC ADMINISTERING VACCINE
		MO/DAY/YR		
Type: DTP DtaP DTP/Hib DT-Pediatric Td-Adult		1		
		2		
		3		
		4		
		5		
Polio		1		
		2		
	Type: OPV	3		
	IPV	4		
	EIPV			
Measles, Mumps, Rubella		1		
		2		
Haemophilus Influenzae b		1		
	Type:	2		
	Hib	3		
	DTP/Hib Hib/HBV			
Hepatitis B		1		
	Type: HBV	2		
	Hep B	3		
Varicella		1		
	Type: Varivax Chicken Pox	2		
Other				
Lead Screen		1		
		2		

PHARMACY \_\_\_\_\_

COMMENTS \_\_\_\_\_

**Reminder:** Make sure  
parents have an  
updated record

Complete & Return this page

# Complete and Return

## Operation SAFE CHILD



Please Print All Information

<b>CHILD'S NAME:</b> _____ First Middle Initial Last			
<b>DATE OF BIRTH:</b> ____/____/____ MM DD YYYY		<b>GENDER: (Circle One)</b> Male Female	
<b>RACE: (Circle One)</b> White Black Hispanic Asian American Indian Bi-Racial Other			
<b>BIRTH CITY/STATE:</b> _____/_____			
<b>EYE COLOR:</b> _____		<b>HAIR COLOR:</b> _____	
<b>HEIGHT:</b> ____ Ft. ____ In.		<b>WEIGHT:</b> _____ lbs.	
<b>MOTHER'S FIRST NAME/MAIDEN NAME:</b> _____/_____			
<b>OTHER INFORMATION:</b> (Piercings, Scars, Marks, Tattoos, Medical Conditions, Medications, Dental Appliances, Corrective Lenses)			

### IMPORTANT INFORMATION

Operation SAFE CHILD cards should be carried by a parent or guardian. In the unlikely event that your child disappears, the card should be provided to the investigating police agency immediately. This will expedite dissemination of missing child information to police agencies and the public.

### AUTHORIZATION

I request that an Operation SAFE CHILD card be produced for the above-named child.

Name (Printed)	Name (Signature)	Relationship to Child	Date
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### FOR PARENTS OR LEGAL GUARDIANS ONLY

Parents and guardians have the option of allowing the photograph, biographical information and fingerprints, to be stored at the NYS Division of Criminal Justice Services. If this option is chosen, all information will be deleted when a child reaches 18 years of age. If this option is not chosen, all information will be deleted after producing the child ID card.

As the parent or legal guardian of the child noted above, I **authorize** **do not authorize** (Circle One)

DCJS to store his/her photograph and biographical information and fingerprints. I understand that this information can be used, without additional authorization, to locate my child if he/she is reported missing to a police agency.

Parent/Legal Guardian Name (Printed)	Parent/Legal Guardian (Signature)	Date
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**Lion SEE, Inc.** is an **Official Project** of the Lions Clubs of New York State & Bermuda. Established in 2004 in Westchester County at the Blythedale Children's Hospital.

In 2008 the program moved to an office at Ross Eye Institute in Buffalo, NY, where early results were processed and follow up was provided by paid interns. The office was closed in August 2015.

The improvements in technology have allowed us to provide instant pass/refer results. All screening and final follow up is now completed by the local Lions.

Lions SEE continues to evolve providing support to Lions who conduct Vision Screenings in Head Start Programs, Preschool and Pre-K Programs, Day Care Facilities and Schools.

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*The vision screening is a free community service project that is financially supported by your local Lions Club.*

For more information about the **MD20 Vision Screening Program**, or to learn about becoming a Lion, please contact your local Lions Club or call 716-881-7915.

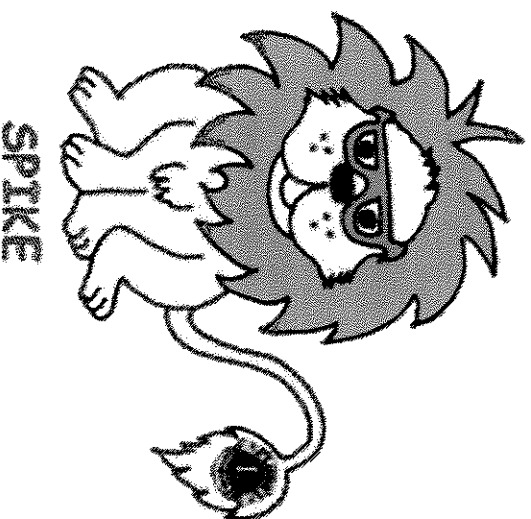
Check out our new website: [www.lionsseeny.org](http://www.lionsseeny.org) for updated forms and information.



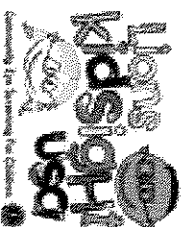
**Multiple District 20**  
New York State & Bermuda Lions

**Lions SEE, Inc.**

Screening Eyes Early



partnering with

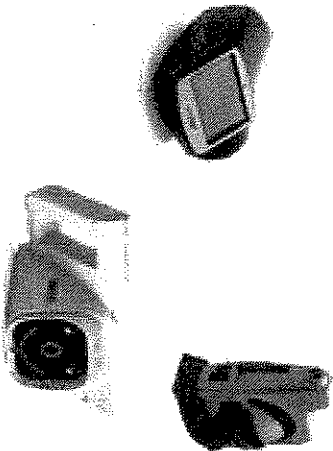


Vision Screening Program for children from 6 months

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## Vision Screening Program

The Lions Clubs in New York State have launched a special program to screen children for vision problems that can lead to Amblyopia, commonly referred to as "lazy eye." The program focuses on screening children between the ages of 6 months and 6 years. The trained volunteers from your local Lions Club will screen the children's eyes with either a Welch Allyn vision screener or a Plusoptix screener.



## Our Goals Are:

- Reach out to parents, schools, and caregivers, emphasizing the importance of early identification of potential vision problems.
- Conduct vision screening sessions for as many children as possible to identify those needing referral for further evaluation by an eye care professional.

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## What we screen for:

The Vision Screeners detect risk factors that may lead to Amblyopia including:

- Myopia - Nearsightedness
- Hyperopia - Farsightedness
- Anisometropia - Unequal refractive power
- Astigmatism - Irregular eye shape
- Media Opacity - cataract
- Strabismus - Eye misalignment

The Vision Screeners are approximately 85 - 95% effective in detecting problems that may lead to amblyopia.

## Why we screen:

According to educational experts, 80% of learning is visual. So if a child can't see well, he can't learn well. Yet most young children don't get their vision screened until they have problems learning or paying attention in school. By then, it may already be too late. Unless vision problems are detected early, they risk becoming permanent by age 7.

In a Sept. 2008 article, Dr Joel Zaba, MA, OD stated, *"Failing to detect and treat vision disorders in children may lead to partial or full blindness, and may result in issues with child development, academic achievement, self-esteem, social-emotional behavior, and juvenile delinquency."*

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## Screening Procedure

The vision screening procedure is simple and non-intrusive. No equipment touches the child. The volunteer Lion holds the device from 14 to 36 inches away from the child. When the child focuses on the screening device's flashing lights, data is recorded.

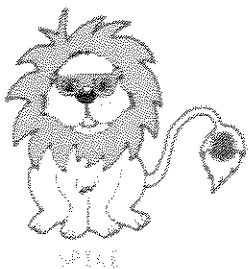


## Our Mission

The mission of Lions SEE, Inc. (Screening Eyes Early) is to decrease childhood blindness through early detection and treatment of the most common vision disorders that cause Amblyopia — insuring that all children of New York State will be able to SEE their future.



# Complete and Return



**LIONS SEE, INC.**  
**A PARTNER WITH KIDSIGHT USA**  
**CONSENT FORM**  
**FREE VISION SCREENINGS ON \_\_\_\_\_**



PLEASE PRINT

Date of

Child's Name \_\_\_\_\_ Birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Student ID

Lions Use Only

**IMPORTANT:** The Lions provide free vision screening as a community service. The Vision Screener is designed to identify vision issues which may lead to amblyopia (Lazy Eye). The screening procedure is non-invasive. There is no physical contact with the child and no eye drops are administered. This screening is not a medical examination. The screening procedure may produce false negative results which may result in a referral when the child is "fine" or the procedure may not detect a vision problem a child has. A comprehensive exam by an eye doctor does not always result in an eyeglass prescription. A doctor may choose to "watch" a condition to see if it progresses. If you feel that the child has a vision problem you should have the child examined by an eye doctor regardless of the results of the screening.

**The parent/guardian will be notified if the results of this vision screening indicate the child is at risk for a vision problem. As post screening follow-up, you will be contacted to determine if the child referred to an eye doctor actually received professional care. If you do not wish to be contacted please check this box:**

**LIONS USE ONLY**

PASSED

REFERRED

I have read the above disclaimer and give permission for the Lions Club to perform this vision screening: \_\_\_\_\_

Parent/Guardian Signature

Date