

Sky Ranch 2017

Please join us for a MANDATORY Parent and Student informational meeting on Tuesday, April 25 at 7:30am in the Commons.

Please feel free to email any OK/MK teachers if you have questions about Sky Ranch and the history of this trip at Rivendell.



The following packet contains information about Rivendell's Sky Ranch Environmental Education Camp.

Cover Letter:

Describes the overall timeline for arrivals, departures, and payments.

Student Conduct Contract:

Please review and sign.

Participant Health Form and Participant Medication Form:

These forms must be signed by a doctor. All medications, both prescription and over-the-counter, must be administered by an authorized adult at Sky Ranch. For example, if you anticipate that your child will need to take Tylenol, there must be a signed (by your doctor) form stating so. Please only use the forms that are provided in this packet. Adults will not administer over-the-counter medications that are not authorized by a physician. See your child's teacher or Elisa in the front office if you need clarification.

Participant Release Form:

This form is for Rivendell and Sky Ranch, and it acknowledges that you give your child permission to participate in all activities.

Visual and Verbal Directions to Sky Ranch:

A map and directions are provided for all participants.

Schedule of the Week:

See what your student will be doing each day.

Packing List:

The packing list is very important. Students and parents, please read it carefully and consider what to bring and what not to bring.

April 1, 2017

Dear Parents and Students:

This packet consists of the information and required forms you and your student/s will need for the Rivendell Environmental Education Camp at Sky Ranch. The cost of your child's trip must be ***paid in full*** by the departure date. See the table below for costs per student.

| Grade | Departure | Return | Summary | Cost |
|-------------|---------------|---------------|--------------------|-------|
| Third | Monday, 5/15 | Tuesday, 5/16 | 1 night, 4 meals | \$155 |
| Fourth | Tuesday, 5/16 | Friday, 5/19 | 3 nights, 10 meals | \$288 |
| Fifth/Sixth | Monday, 5/15 | Friday, 5/19 | 4 nights, 13 meals | \$350 |

**Cost per student include expenses for subs and teacher pay for chaperoning this event. Rivendell pays half of this total cost (substitutes, cost of teachers to stay at Sky Ranch, etc.), and the remaining half is divided among the expected number of participants.*

Payment:

Please make your check out to **Rivendell School**. Checks written for Sky Ranch will not be deposited until the week of the camp. All outstanding balances, tuition and daycare charges, must be paid *prior* to camp week for your student to be allowed to attend Sky Ranch.

*If your child will not be going to Sky Ranch, other arrangements will need to be made by the family. Unless your child is in third grade, **there are NO classes or extended hours while the class is away.***

Supervision:

This year our Rivendell chaperones include Older Kids Teachers Sarah and Suzanne and Middle Kids Teachers Bryce and Anna. Bryce, Sarah and Suzanne will be at Sky Ranch Monday through Friday. Anna and Holly will be there Monday and Tuesday. Larry Tucci, Rivendell parent and volunteer, will also be staying all week.

Transportation:

The trip takes approximately three hours *round trip*. A parent volunteer will be coordinating all transportation and carpooling options. Each family will be contacted by Ewa Limanska-Moran (Rivendell Parent) via email and/or phone to verify ability for driving. After arrival at Sky Ranch, parent drivers are requested to leave Sky Ranch by 10:30am. Rivendell is not coordinating transportation.

On departure day your camper needs to be at Rivendell by 8:15am with all his/her gear. The carpool will leave promptly at 8:30am. Lunch will be served at Sky Ranch to the campers upon arrival. There is no need to pack a lunch for that day.

It is highly recommended that campers be picked up at Rivendell as soon as they return from Sky Ranch (approximately 2:00pm). The kids will be tired and ready to see you!

It's going to be a great adventure!

Sincerely,
Holly



Camper Behavior Contract

I understand the Sky Ranch Environmental Education Week is a planned part of the Rivendell curriculum. The same behavioral expectations are in effect at Sky Ranch as during the school day at Rivendell. Respect for adults and the other students is essential to assure the safety of everyone, as well as providing an enjoyable experience.

I promise to use appropriate language, exhibit responsible behavior and cooperate with the adults in charge. I understand the failure to do so will result in my parents being called to pick me up.

Student's Name _____

Student's Signature _____

Parent Name _____

Parent Signature _____

Transportation Release

Rivendell has asked that each family provide their own transportation for your child to arrive at and return from Sky Ranch. A volunteer has helped coordinate carpooling with all families of children attending.

I understand Rivendell is not responsible for my child's transportation to and from Sky Ranch. I also understand that Rivendell is not liable for any incidents that may happen in the transport of my child to and from Sky Ranch.

Parent Name (Printed)

Parent Signature

Child's Name



PARTICIPANT RELEASE FORM 2017

RETURN WITH YOUR BALANCE DUE AT LEAST 3 WEEKS PRIOR TO ARRIVAL. (Keep a copy for your records.)

Entered
Scanned

This form must be filled out annually in order to participate in Sky Ranch programs. Please type or print. Fill out one form for each camper attending. Return with your balance due within 3 weeks prior to arrival.

Mail to: Sky Ranch Lutheran Camp 805 S Shields St Fort Collins, CO 80521
Fax to: 970-493-7960

If you have any questions filling out this form, please email us (info@SkyRanchColorado.org) or call our office (970-493-5258)

Camper Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ ST: _____ Zipcode: _____

Church: _____ Grade Complete (As of June 1, 2017): _____

PARENT OR GUARDIAN INFORMATION: (Adult participants do not need to complete this section.)

Guardian Name: _____ Email: _____

Address: _____ City: _____ ST: _____ Zipcode: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Employer: _____ Address: _____

ALTERNATIVE EMERGENCY CONTACT INFORMATION: (Someone different from above.)

Contact Name: _____ Relationship: _____

Address: _____ City: _____ ST: _____ Zipcode: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

PERSONS AUTHORIZED TO TRANSPORT CHILD: Either Parent Mother Only Father Only Pastor / Youth Director

To specify unauthorized individuals, contact our office directly. Name: _____ Home Phone: () _____

I hereby release Sky Ranch Lutheran Camp, its agents, members, and employees, from all liability for any accident, injury or claim arising from the camper named above's use of any of it's facilities, or participation in any of it's programs.

In case of emergency, I understand every effort will be made to contact me and the authorized persons named above. I understand our congregational contact will handle primary medical response. In the event we cannot be reached, I give my permission to camp officials to provide for the camper named above any medical or surgical care. I understand that Lutheran Ranches of the Rockies (dba Sky Ranch Lutheran Camp) does not carry health/accident insurance on its campers and I will accept the expense of emergency medical or surgical treatment through personal insurance or personal resources.

Sky Ranch Lutheran Camp may use, for promotional purposes, any photographs & video taken of the camper named above.

I give permission for the camper named above to go on Sky ranch Lutheran Camp staff supervised trips away from camp premises, whether on foot or by vehicle.

I give permission for the camper named above to participate in all appropriate elements of the High & Low Ropes challenge course. I understand that campers who have completed grade six and older can participate in high challenge elements, but that low challenge activities are available with age appropriate activities for all ages.

I give permission for the camper named above to participate in all camp activities with the following exceptions:

X

(Signature of Parent, Guardian or Adult Participant)

(Date)

I understand and agree to abide by any restrictions placed on my participation in camp activities. I agree to abide by all policies regarding personal conduct. If I do not cooperate, or become a hindrance to the camp program, I understand I will be sent home.

X

(Signature of Camper)

(Date)



Last :

First :

Week:

Program:

Church:



PARTICIPANT HEALTH FORM 2017

RETURN WITH YOUR BALANCE DUE AT LEAST 3 WEEKS PRIOR TO ARRIVAL (Keep a copy for your records)

Last Name: _____ First Name: _____ Male Female
 Health Insurance: _____ Birth Date: _____ Age: _____
 Policy #: _____ I have no Insurance Grade (as of Nov 2017): _____

- All camp participants (including adults) must have a physical exam within the last 24 months prior to arriving at camp. Please attach a copy of that exam, if available. If you have not had an exam in the last 24 months, you must schedule one at least 3 weeks prior to camp.
- All camp participants must also complete the Colorado Health Depart. Certification of immunization (available on our website). For out-of-state participants who may not be up-to-date for CO standards, the parent/guardian/adult may sign the personal exemption section.
- All camp participants must complete this health form, including a parent/guardian/adult signature and a doctor's signature on the back of this form.
- Any camper with medications must list each medication separately (this includes prescription, over-the-counter, and vitamins) on the back of this form. A doctor must complete the medication portion of the health form.
- Please mail/fax/email to the Sky Ranch office no later than 3 weeks prior to your camp arrival. Call with any questions: 970-493-5258 (office) 970-493-7960 (fax)

HEALTH HISTORY

Does the camper have a history of any of the following? (Check all that apply)

- Seizures/Convulsions Diabetes Cancer/Leukemia Mononucleosis ADD/ADHD
 Fainting/Dizzy Spells Heart Disease/Defect Bleeding/Clotting Disorder Altitude Sickness Asthma
 Head Injury High Blood Pressure Menstrual Problems Sleepwalking Bi-Polar
 Frequent Headaches Frequent Ear Infections Kidney Disease Eating disorder _____

Please explain any history that may impact the camper's experience or special care that should be taken _____

MENTAL HEALTH

In order to keep your camper safe, is there any mental health history we should be aware of? (Please describe below)

ASTHMA & ALLERGIES

PLEASE Complete additional Asthma &/or Allergy Health Care Form (Epi Pen Action Plan).
Campers &/or counselors will be allowed to carry asthma inhalers & epi pens.

- No known Allergies Foods _____ Insect Stings _____
 Medications _____ Other _____

SPECIAL DIET

- Vegetarian Gluten Free Lactose Free Please describe any special dietary restrictions or requirements: _____

MEDICATION INSTRUCTION

- All medications (prescriptions, over-the-counter, and vitamins) MUST be documented with accurate directions on the next page by a physician or registered nurse.
- All prescription medications, over-the-counter medications, and vitamins MUST be in original, non-expired container with current accurate directions and dosage.
- Pill minders, plastic bags, etc, are not acceptable for any medication.
- Campers will be allowed to carry asthma inhalers & epi pens with them. Please fill out Asthma/Epi Pens action plan forms. You can attach asthma/epi pens action plans forms used for the school year as well.

STOCK OVER-THE-COUNTER MEDICATIONS

These are the over-the-counter medications stocked in the health clinic at Sky Ranch. These medications are overseen and administered by our volunteer health supervisor.

Please check off any medications that YOU DO NOT APPROVE and initial here:

CROSS OFF IF NOT APPROVED

| | | |
|--|--------------------------------|--|
| Acetaminophen/Tylenol (headache) | Alcohol Wipes (skin cleansing) | Aloe Vera Gel (sun burn) |
| Anbesol (tooth/gum pain) | Ammonia Inhalants (fainting) | Antacid/Tums (upset stomach) |
| Aquaphor | Antibiotic Ointment (scrapes) | BSK Wipes (antiseptic wipes) |
| Calamine Lotion (rashes, insect bites) | Campho-Phenique (cold sores) | Cold Pack/ Ice |
| Cough Drops | Cough Syrup | Diphen/Benedryl (allergy, itching, rashes) |
| Emergen-C | Hydrocortisone CR | Heat Pack/Pad |
| Ibuprofen/Advil | Imodium (anti-diarrhea) | Instal-Glucose (insulin reactions) |
| Moleskin | Saline eye wash | Sunscreen |
| Pseudoval/Sudafed (congestion) | Gold Bond Powder | Bio Freeze |



PARTICIPATION HEALTH FORM 2017

A PHYSICIAN OR LICENSED NURSE PRACTITIONER MUST COMPLETE & SIGN THIS PAGE ALONG WITH PARENT SIGNATURE

LAST NAME: _____ FIRST NAME: _____

MEDICATION INSTRUCTIONS (IF APPLICABLE)

- All medications (prescriptions, over-the-counter, and vitamins) **MUST** be documented with accurate directions listed below. Please make sure that a physician or licensed nurse practitioner fills out medications.
- All prescription medications, over-the-counter, and vitamins **MUST** be in the original, non-expired container with current accurate directions and dosages.
- Pill mills, plastic bags, etc, are not acceptable for any medication.
- Campers/counselors will be allowed to carry asthma inhalers & epi pens with them. Please fill out the Asthma and Epi Pen action plan forms. Campers can attach any school asthma/cpi pen action plan form if current.
- We encourage that if your camper takes commonly used over-the-counter medications on an occasional basis, like those for pain and allergies, that you leave them at home. We stock these medications on site.
- If your camper takes over-the-counter medications on a daily basis, please list below.

Please provide the following information for EACH medication you are bringing to camp, including vitamins and over-the-counter medication.

MEDICATION #1

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: As Needed AM PM Other _____ Taken with Food

Reason for Giving _____

MEDICATION #2

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: As Needed AM PM Other _____ Taken with Food

Reason for Giving _____

MEDICATION #3

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: As Needed AM PM Other _____ Taken with Food

Reason for Giving _____

MEDICATION #4

Medication Name (EXACT NAME) _____ Dosage (mg/ml & tab/capsule) _____

Administration Time: As Needed AM PM Other _____ Taken with Food

Reason for Giving (Special Instructions) _____

PARENTAL OR GUARDIAN RELEASE

- I approve of the over-the-counter medications listed on the front page for use as needed by the camper identified above. I have crossed off any medications that are not approved for use by said camper.
- I hereby request and give my permission to the Sky Ranch Lutheran Camp health supervisor to administer medication to the camper identified above. I understand that all medications must be provided in the original pharmacy labeled container. I understand my child assumes responsibility for going to the health clinic at specified times for medications.
- I hereby give my permission to Sky Ranch Lutheran Camp to give care to the camper identified above in case of illness or injury and understand Sky Ranch Lutheran Camp will attempt to contact me in such event.

Signature of Parent, Guardian, or Adult Participation

Date

PHYSICIAN OR LICENSED NURSE PRACTITIONER RELEASE

- I have approved the medications and dosages listed above for use by the camper identified above.
- I approve the stock over-the-counter medications listed on the front page for use as needed by the camper identified.
- I have examined the camper listed above within the last 24 months and have reviewed the health history. It is my opinion that this camper is in satisfactory condition and capable of engaging in all camp activities, unless noted otherwise.

Signature of Physician or Licensed Nurse Practitioner

Date

Printed Name _____ Phone Number _____

Printed Address _____

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____
 School: _____ Teacher: _____
ALLERGY TO: _____
HISTORY: _____



Asthma: YES (higher risk for severe reaction) NO

◇ STEP 1: TREATMENT ◇

SEVERE SYMPTOMS: Any of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy,
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Significant swelling of the tongue and/or lips
- SKIN: Many hives over body, widespread redness
- GUT: Repetitive vomiting, severe diarrhea
- OTHER: Feeling something bad is about to happen, confusion



1. **INJECT EPINEPHRINE IMMEDIATELY**
 2. Call 911 and activate school emergency response team
 3. Call parent/guardian and school nurse
 4. Monitor student; keep them lying down
 5. Administer Inhaler (quick relief) if ordered
 6. Be prepared to administer 2nd dose of epinephrine if needed
- *Antihistamine & quick relief inhalers are not to be depended upon to treat a severe food related reaction . **USE EPINEPHRINE***

MILD SYMPTOMS ONLY:

- NOSE: Itchy, runny nose, sneezing
- SKIN: A few hives, mild itch
- GUT: Mild nausea/discomfort



1. Alert parent and school nurse
2. Antihistamines may be given if ordered by a healthcare provider,
3. Continue to observe student
4. If symptoms progress **USE EPINEPHRINE**
5. Follow directions in above box

DOSAGE: Epinephrine: inject intramuscularly using auto injector (check one): 0.3 mg 0.15 mg

If symptoms do not improve in _____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given

Antihistamine: (brand and dose) _____

Asthma Rescue Inhaler: (brand and dose) _____

Student has been instructed and is capable of carrying and self-administering own medication. Yes No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

If this condition warrants meal accommodations from food service, please complete the medical statement for dietary disability

◇ STEP 2: EMERGENCY CALLS ◇

1. If epinephrine given, call 911. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

2. Parent: _____ Phone Number: _____

3. Emergency contacts: Name/Relationship Phone Number(s)

a. _____ 1) _____ 2) _____

b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

Staff trained and delegated:

1. _____

Room _____

2. _____

Room _____

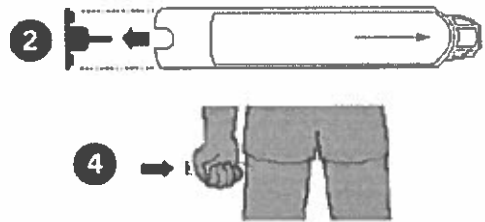
3. _____

Room _____

Self-carry contract on file: Yes No

EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Firmly push orange tip against outer thigh.
4. Hold for approximately 3 seconds.
5. Remove and massage area for 10 seconds.



ADRENACLICK™/ADRENACLICK™ GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

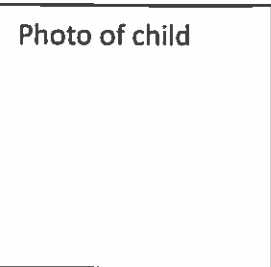


Expiration date of epinephrine auto injector: _____

NOTE: Consider lying on the back with legs elevated. Alternative positioning may be needed for vomiting (side lying, head to side) or difficulty breathing (sitting)

Additional information: _____

COLORADO SCHOOL ASTHMA CARE PLAN



PARENT/GUARDIAN complete and sign the top portion of form.

| | |
|------------------|-------------|
| Student Name: | Birth date: |
| Parent/Guardian: | Work Phone: |
| Cell Phone: | Home Phone: |
| Other Contact: | Phone: |
| Grade: | Teacher: |

Triggers: Weather (cold air, wind) Illness Exercise Smoke Dust Pollen Other: _____
 Life threatening allergy : Specify _____

If there is **no** quick relief inhaler at school and the student is experiencing asthma symptoms:
 ➤ Call parents/guardians to pick up student and/or bring inhaler/ medications to school
 ➤ Inform them that if they cannot get to school, 911 may be called

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ 504 PLAN OR IEP
 PARENT SIGNATURE DATE SCHOOL NURSE SIGNATURE DATE

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: Not Required
 Pretreatment for strenuous activity: Routinely **OR** Upon request Explain: (weather, viral, seasonal, other) _____
 Give 2 puffs of quick relief med (Check One): Albuterol Other: _____ 10-15 minutes before activity.
 Repeat in 4 hours if needed for additional or ongoing physical activity.
If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

| IF YOU SEE THIS: | DO THIS: |
|---|---|
| <ul style="list-style-type: none"> ▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between _____ and _____ ▪ Other: _____ | <ol style="list-style-type: none"> 1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. <i>If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.</i> |

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

| IF YOU SEE THIS: | DO THIS IMMEDIATELY: |
|--|--|
| <ul style="list-style-type: none"> ▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < _____ | <ol style="list-style-type: none"> 1. GIVE QUICK RELIEF MED: (Check One): <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs). 8. <i>School personnel should not drive student to hospital.</i> |

INSTRUCTIONS for QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)
 Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse.
 Student is to notify his/her designated school health officials after using inhaler.
 Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) _____

HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER'S NAME PHONE/FAX DATE
 Copies of plan provided to: Teacher(s) _____ Phys Ed/Coach _____ Principal _____ Main Office _____ Bus Driver _____ Other _____

NON-MEDICATION CONSENT FORM

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, and sunscreen products .
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- One form must be completed for each over-the-counter product.
- All products be in the original container or packaging and must match the description of the product listed on the form.
- Multiple products cannot be listed on one form.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

Parent or Guardian to fill out (# 1 - 14)

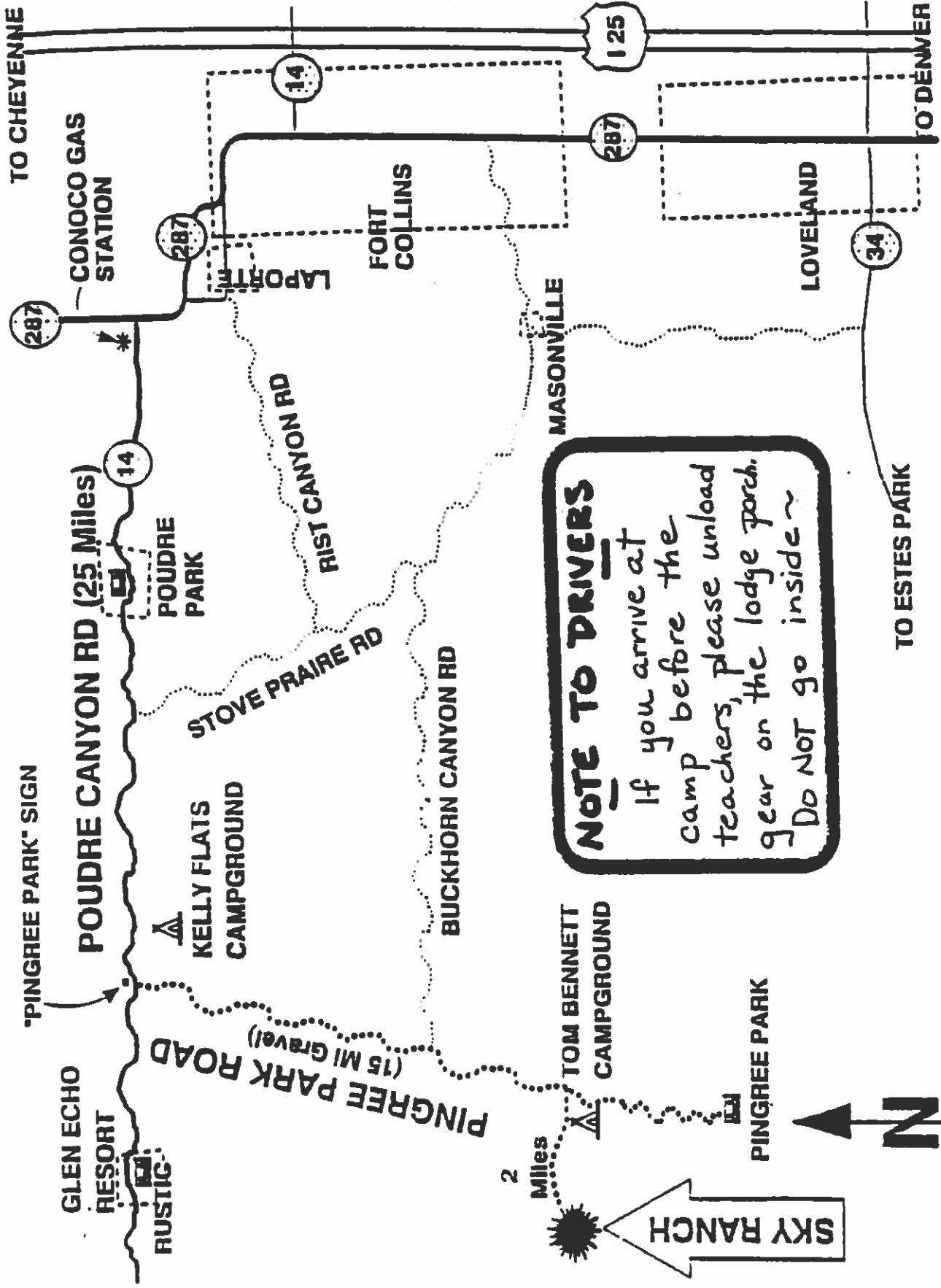
| | | |
|--|------------------------------|----------------------------|
| 1. Child's first and last name | 2. Date of Birth | 3. Known allergies |
| 4. Name of product (including strength) | 5. Amount to be administered | 6. Route of administration |
| 7A. Frequency to be administered, include times of day if appropriate: _____ | | |
| OR _____ | | |
| 7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____ _____ | | |
| 8A. Possible side effects: <input type="checkbox"/> See product label for complete list of possible side effects (parent must supply) | | |
| AND / OR | | |
| 8B: Additional side effects: _____ | | |
| 9. What action should the child care provider take if side effects are noted: <input type="checkbox"/> Contact parent : _____ _____ | | |
| <input type="checkbox"/> Other: (describe) _____ | | |

Rivendell School employee to fill out (# 15 - 21)

| | | | |
|--|--|------------------------------|--|
| 15. Program Name: Rivendell School | | 16: Program Id: 1504578 CDHS | 17: Program Telephone Number: (970) 493-9052 |
| 18. I have verified that #1, #14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program. | | | |
| 19: Staff Name (print clearly): | | 20: Staff Signature: | 21: Date received from parent or guardian: |

| | |
|--|-------------------|
| 14: Parent Signature(s): | |
| 12: Parent Name: | 12b: Parent Name: |
| 13: Date Authorized: | |
| <input type="checkbox"/> 10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (parent must supply) AND/OR <input type="checkbox"/> 10B. Additional special instructions: <input type="checkbox"/> 11. Reason(s) for use (unless confidential by law): | |

NON-MEDICATION CONSENT FORM



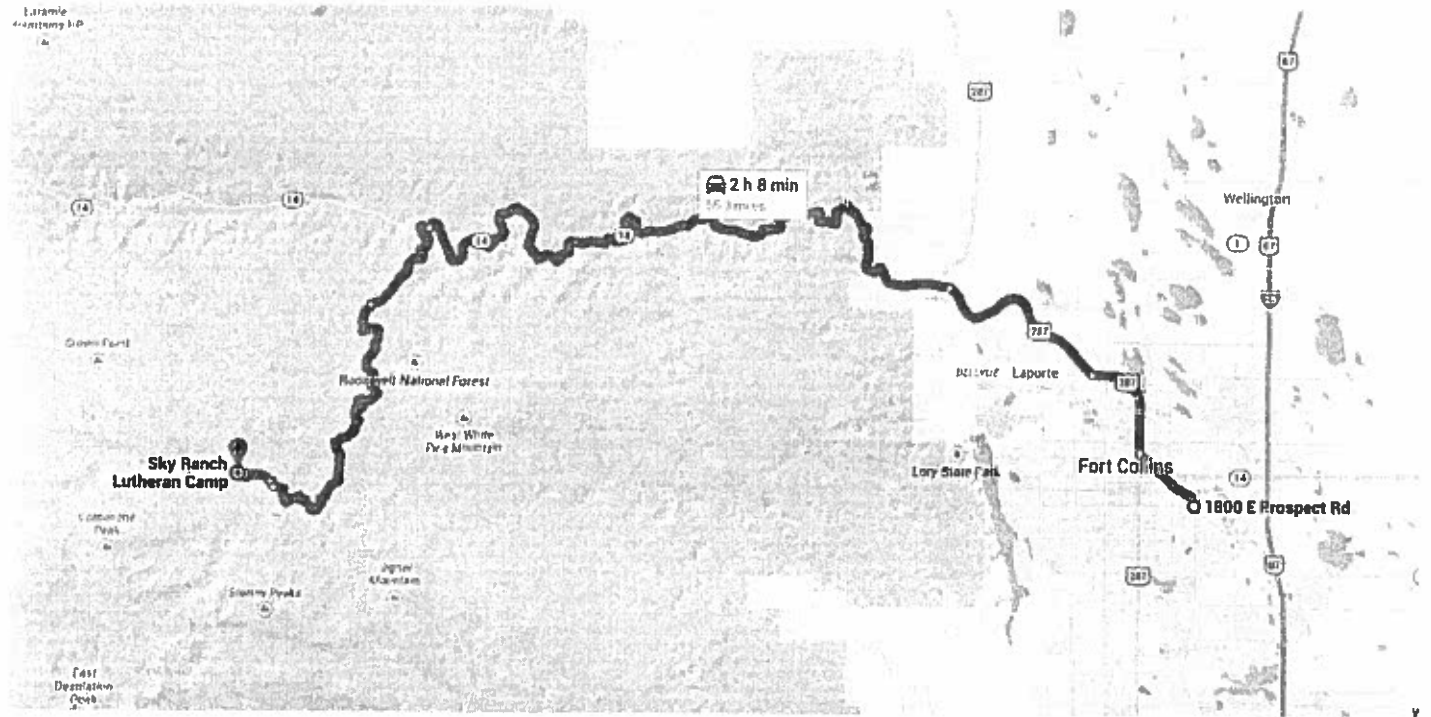
NOTE TO DRIVERS
 If you arrive at camp before the teachers, please unload gear on the lodge porch. Do NOT go inside~



MAP TO SKY RANCH



Directions from 1800 E Prospect Rd to Sky Ranch Lutheran Camp



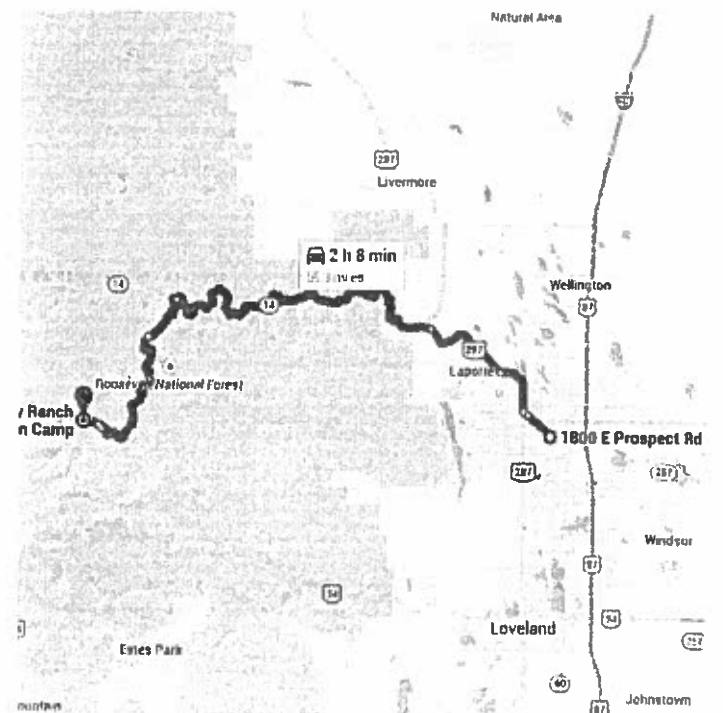
o 1800 E Prospect Rd

Fort Collins, CO 80525

Take CO-14 W to Pingree Rd

38.2 mi / 56 min

- ↑ 1. Head west on E Prospect Rd
102 ft
- ↘ 2. Turn right onto Riverside Ave
2.1 mi
- ↑ 3. Continue onto Jefferson St
0.4 mi
- ↘ 4. Turn right onto CO-14 W/US-287 N/N College Ave
 - ⓘ Continue to follow CO-14 W/US-287 N
3.5 mi
- ⤴ 5. Take the ramp onto CO-14 W/US-287 N
6.1 mi
- ↙ 6. Turn left onto CO-14 W
26.2 mi

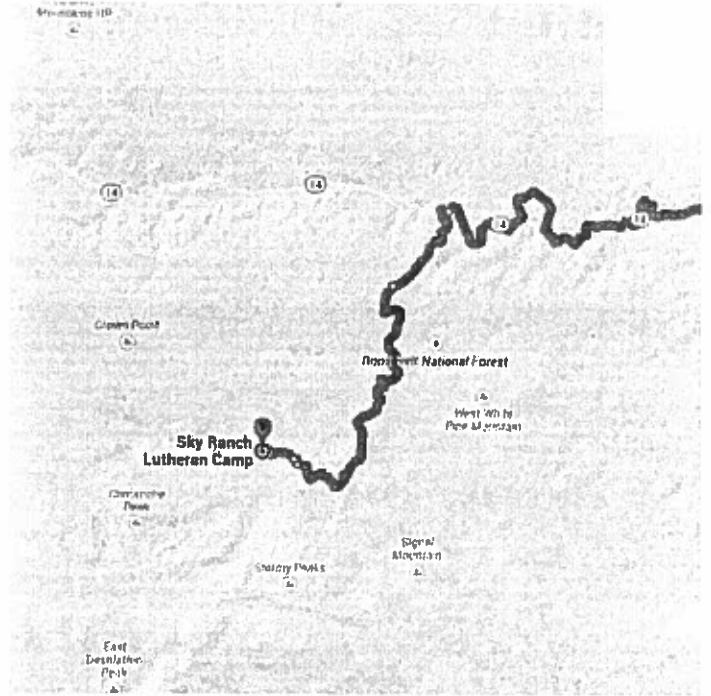


Take N Co Rd 63E/Pingree Park Rd to W Co Rd 145 Campground

17.0 mi / 1 h 10 min

- 7. Turn left onto Pingree Rd 4.2 mi
- 8. Slight left onto N Co Rd 63E/Pingree Park Rd 11.2 mi
- 9. Turn right onto W Co Rd 145 Campground 0.3 mi
- 10. Turn right to stay on W Co Rd 145 Campground 1.3 mi

i Destination will be on the left



📍 Sky Ranch Lutheran Camp

38999 County Road 44H, Bellvue, CO 80512

These directions are for planning purposes only. You may find that construction projects, traffic, weather, or other events may cause conditions to differ from the map results, and you should plan your route accordingly. You must obey all signs or notices regarding your route.

Map data ©2015 Google

SUPPLY CHECKLIST

The following is a supply list of recommended clothing and equipment that students should bring with them to camp. Keep in mind that the majority of our time will be spent outdoors, so bring plenty of warm clothes, shoes/boots and raingear. At 9200 feet, the climate tends to be more winter-like during spring.

Plenty of Warm Clothing (adjust to the number of days you are attending)

- Warm pajamas
- 2-3 pairs of jeans or pants
- Warm sweaters/jackets
- Daily change of socks and underwear (extra socks are recommended)
- Heavy and light shirts
- 2 pairs of sturdy footwear (hard-soled shoes helpful)
- Raingear
- Knit cap or hat with brim
- Heavy jacket or coat
- Mittens/gloves

Bedding: (Sky Ranch provides bunk beds and mattresses)

- Sleeping bag or at least two blankets
- Pillow

Toiletries:

- Toothbrush and paste
- Soap
- Towel and wash cloth
- Brush/comb
- Chapstick/Lip balm with sunscreen
- Tissues

Mandatory Items:

- Water bottle
- Whistle on a chain, cord or lace
- School-type backpack, not camping style
- Sunscreen

Useful Items:

- Notebook or writing paper
- Pencils/Pens
- Camera
- Flashlight/Headlamp
- Books to read

DO NOT BRING: Valuable items, jewelry, knives, any kind of food, candy or gum, TV, radio, I-Pod, I-Pad, laptops, video games, pets.....

Rivendell School and Sky Ranch are nor responsible for campers' personal items. It is recommended that all items are marked with the student's name.

