Kidney camp is back for Summer 2022. We can't wait to see our campers!!

This is the first step in registering your child for kidney camp

**Because camper safety is our priority, we must receive camper registration info, a medical summary from nephrologist, and all releases prior to scheduling. We will be in touch with parents and teams by email over the next few months. Forms are also available on our website**

[http://www.frostvalley.org/kidney](http://www.frostvalley.org/kidney)

Once medically reviewed, campers are scheduled based on session requested and available space. Spaces are filled as we get applications, and accepted until we have no more room, we do run a waiting list if needed. Our due date for initial applications and medical summaries is **March 15, 2022.**

**Please Note:**

- Kidney campers MUST arrive at camp with 14 days worth of all medications with them from home in original labelled bottles from your pharmacy (not pre-poured), packed separately in a bag or cooler labeled with their name.
- Camp is hilly, and there is considerable walking. Kidney campers should be able to walk 200 yards unassisted (without walker, cane, etc.). If there are ambulation challenges, please let us know so we can plan accommodations if possible.
- Campers on peritoneal dialysis must be trained in CAPD in their home unit (our staff will be assisting them at camp). Our nurse coordinator would be happy to discuss, please ask!
- Transplant campers must be at least one year post-transplant.
- We cannot accommodate femoral catheters, overnight GT feeds (or other overnight equipment) at camp. Please notify us if a camper has enuresis (bedwetting) or requires GU catheterization, so we can prepare accordingly.
- Children with developmental or learning disabilities may be eligible for YAI’s Project MAC; please notify our coordinator early on if your camper might benefit from this program.
- We will do our best to accommodate your child’s unique needs, so please discuss and document early!
- We want your kidney campers to have an enjoyable and rewarding experience and we appreciate your assistance in these preparations.
Please feel free to contact the coordinators or medical director at the Children’s Hospital at Montefiore at (718) 655-1120 or by email if you have any questions or require any additional information. (Faster reply by email!!)

Maya Doyle, LCSW, PhD
Social Work/Coordinator
mdoyle@montefiore.org

Elena Cotillo, RN
Dialysis Nurse/Coordinator
ecotillo@montefiore.org

Rick Kaskel, MD, PhD
Medical Director
Kidney Camper Information

1. First Name:

2. Last Name:

3. Nickname:

4. Gender Identity:

5. Please enter camper’s birthdate (month/day/year)

Date:

Date

MM/DD/YYYY

6. Age at camp:

7. Grade this fall:
* 8. Parent/Guardian:

Name
Address
Address 2
City/Town
State/Province
ZIP/Postal Code
Email Address
Phone Number
Session and Transportation

* 9. Type of Camper:

- [ ] Hemo
- [ ] P D
- [ ] Transplant
- [ ] CKD >Stage 3:

* 10. Session Preference (Check all that apply)

- [ ] Resident Camp 1: 06/26/2022 – 07/08/2022
  (CKD and transplant campers; all dialysis campers must register for session 1)
- [ ] Resident Camp 2: 07/10/2022 – 07/22/2022
  (CKD and Transplant campers only)
- [ ] Either session works for us!
- [ ] Resident Camp 3 or 4 may be available for RETURNING kidney campers age 14 and up who need minimal medical supervision. Camp coordinator will follow up to discuss availability.
- [ ] Former kidney camper applying to be a counselor in training (CIT)
  (must have applied via Frost Valley process)

* 11. Transportation

<table>
<thead>
<tr>
<th>Location</th>
<th>Which way?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manhattan bus – 460 West 34th Street</td>
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<tr>
<td>Brooklyn bus - 225 Atlantic Ave.</td>
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<tr>
<td>Montclair High School (NJ) bus</td>
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<tr>
<td>Newark bus - 1 Avon Ave.</td>
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<tr>
<td>DRIVING</td>
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</table>

Other (please specify)
Medical Info

* 12. Kidney diagnosis:

13. Other medical issues

- [ ] Bedwetting
- [ ] GU catheterization
- [ ] Injectable meds (epo, growth hormone, insulin)

Other (please specify)

* 14. ALLERGIES:

15. Type of Dialysis Access:

Other details:

16. Dialysis Schedule:

- [ ] MWF
- [ ] TuThSa
t
- [ ] Not on dialysis

Other details:
Contact Info

17. Emergency Contact

Name ______________________________
Relationship ________________________
Email Address ______________________
Phone Number _______________________

* 18. Medical Center

Company ___________________________
City/Town __________________________
State/Province _______________________

* 19. Nephrologist

Name ______________________________
Email Address _______________________
Phone Number _______________________

20. CKD Nurse/Dialysis Nurse/Transplant Coordinator

Name ______________________________
Email Address _______________________
Phone Number _______________________

21. Social Worker

Name ______________________________
Email Address _______________________
Phone Number _______________________
### 22. Other provider (therapist, other specialty physician, etc)

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Company</td>
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### 23. Pharmacy

<table>
<thead>
<tr>
<th>Contact Person</th>
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<tbody>
<tr>
<td>Pharmacy Name</td>
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<td>Email Address</td>
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<td>Phone Number</td>
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</table>
Detailed info is necessary so that we can provide safe and accurate treatment to your camper while at camp and in an emergency if one should arise!!

Please submit the following by March 15, 2022 by email to mdoyle@montefiore.org:

- Signed release of information and treatment consent and signed photo release- [click to get form]
- Medical Summary from Nephrologist & a recent history & physical

CAMPERS WILL NOT BE SCHEDULED UNTIL THIS INFORMATION IS RECEIVED. We cannot “reserve space” for children without this paperwork.

You will know you child is registered when you receive an email from CampDoc which will include health assessment, immunizations, insurance cards, and “tips for success”.

In the month prior to camp, you and your medical team will be asked to submit a Transfer Summary, med list, and child's most recent labs. ([click for forms](#)). Dialysis campers will also be asked to submit:

- Montefiore Dialysis Consent Form signed by parent and home nephrologist) ([click for form](#))
- Transient Dialysis Forms (Hemo or PD) ([click for form](#))
- Current Comprehensive Plan of Care from Home Unit (REQUIRED)
- Dialysis Flow Sheets (2 weeks HD, or monthly PD)
- Please DO NOT send dialysis flow sheets or orders until one month before camp as they will need to be updated before camp.

Please contact our [coordinator](#) if you have any difficulty with the process!!
Ruth Gottscho Dialysis and Children’s Kidney Program at Frost Valley YMCA  
www.frostvalley.org/kidney

Release of Information

I, ____________________________, parent or guardian of ____________________________, consent to the release of medical information about my child from our healthcare provider to the Ruth Gottscho Dialysis and Children’s Kidney Program, a division of the Children’s Hospital at Montefiore, Bronx, NY.

I understand that while at camp, my child becomes a patient of Montefiore Medical Center, and they are subject to Montefiore’s policy regarding protected health information, in accordance with the Health Information Portability and Accountability Act (HIPPA).

(for an additional copy of Montefiore’s HIPAA policy, please contact camp coordinator)

Parent/Guardian Signature__________________________________________________ Date________

Permission for Diagnosis and Treatment

I, ____________________________, parent or guardian of ____________________________, give my permission to the medical and nursing staff of the Ruth Gottscho Dialysis and Children’s Kidney Program at Frost Valley YMCA, a division of the Children’s Hospital at Montefiore, to provide medical and nursing care for the above minor. This permission includes medication administration, catheterization, CAPD or hemodialysis, for children receiving these forms of treatment.

Parent/Guardian Signature__________________________________________________ Date________

Photo Consent

I, ____________________________, parent or guardian of ____________________________, hereby grant to: Children’s Hospital at Montefiore, Frost Valley YMCA, and Ruth Gottscho Kidney Foundation without compensation therefore, permission to photograph, publish, reproduce, record and use, with or without his/her name, photographs, motion pictures, video or audio of my child or in which he/she appears, and permission to discuss his/her medical problems/diagnoses and treatment for any and all purposes, including but not limited to publication and/or broadcast of this material for education, clinical, scientific, informational, advertising, and promotional and medical publicity purposes, and I release the aforementioned parties from any and all claims or liability that may arise from any of the foregoing. I agree that all photographs, motion pictures, video, and audio made of my child by or for the above-mentioned parties shall be their exclusive property, which in their discretion may be used as they see fit. I grant this permission and release as a voluntary contribution and I waive any and all rights I may have to royalties or other compensation in.

Parent/Guardian Signature__________________________________________________ Date________

________________________________________
Signatureprinted name of minor subject, if old enough to understand
Ruth Gottscho Dialysis and Children’s Kidney Program
at Frost Valley YMCA
www.frostvalley.org/kidney

Medical Summary
REQUIRED FROM NEPHROLOGIST
PRIOR TO CAMP ACCEPTANCE

______________________________ is applying for kidney camp for a session this summer.

In order to accept this child for camp, we must be able to review their medical information by March 15, 2019.

Please provide a detailed, typed medical summary including:

- ESRD/CKD diagnosis
- other diagnoses
- history & physical
- recent hospitalizations
- recent labs
- allergies & immunizations
- developmental/learning/behavioral issues
- recent psychosocial or letter from social worker appreciated
- current problems
- current medications and dialysis prescription

For dialysis patients, please provide recent URRs or Kt/V’s, and describe any access problems.
For transplant patients, please describe any chronic/acute rejection, or recurrence of FSGS/plasmapheresis.

Please describe any pertinent issues regarding coping, adherence, mental health or behavior.
Include a summary from social work, and from psychologist or psychiatrist if necessary.

*If child is seen by another specialist (endocrinology, cardiology, neurology, etc), please be sure to include information and contacts for them.*

Please attach a copy of a RECENT History & Physical with your letter.

We will request a brief transfer form, labs, and current med list, in the month prior to camp arrival, and transient dialysis forms and prescription if needed.

If you have any questions regarding whether your patient is medically appropriate for camp, please contact Dr. Kaskel at 718-655-1120, or Maya Doyle at mdoyle@montefiore.org.
All camp application materials should be faxed to 718-652-3136, Att: Kidney Camp, or emailed to mdoyle@montefiore.org

We do our best to accommodate the needs of every child; communication is key!
Psychosocial Summary

Please attach a thorough psychosocial summary, and include any relevant information from social worker and any other mental health professionals or child life therapists working with child. Please detail any coping or behavioral concerns (including medication adherence) that child has recently experienced or might experience at camp.

Mental, Emotional, and Social Health: Check “Yes” or “No” for each statement.
Has the camper:
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?
   Yes ☐  No ☐
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?  Yes ☐  No ☐
3. During the past 12 months, seen a professional to address mental/emotional health concerns?
   Yes ☐  No ☐
   If so, name and contact info.............................................................................................................................................
4. Had a significant life event that continues to affect the camper’s life?
   (new diagnosis, loss of transplant, death of a loved one, family change, adoption/foster care, new sibling, survived a disaster, violence or abuse, other)
   Yes ☐  No ☐

Please explain “Yes” answers in the space below and/or attach an additional letter or report. We may contact you for additional information so that we can best meet camper’s needs.

Completed by:________________________________________________________
Phone:______________________________________________________________
Date:__________
Ruth Gottscho Dialysis and Children’s Kidney Program at Frost Valley YMCA
www.frostvalley.org/kidney

Camper Name: _______________________________________________________________

We are pleased to inform you that your child has been accepted to the Ruth Gottscho Dialysis and Children’s Kidney Program at Frost Valley YMCA for:

- Resident Camp 1: June 28 – July 10, 2020
- Resident Camp 2: July 12 – July 24, 2020

Please meet with your healthcare team to complete the enclosed transfer forms, which should be faxed to (718) 652-3136 or emailed to mdoyle@montefiore.org.

- We must receive transfer forms in the month of JUNE prior to arrival at camp, along with recent/June labs and all transient dialysis forms.
- Children without complete information will not be accepted. We will also be contacting your healthcare team.
- Children should arrive with a **14-day supply** of all medications, which should be in the original labelled containers or packets from the pharmacy, NOT pre-poured or in a med box.
- Please double-check ALL meds before your child boards the bus! Medications and any additional paperwork should be carried in a separate bag and brought immediately to the Wellness Center upon arrival at camp or given to counselors on the bus. We suggest you include an extra copy of insurance or prescription coverage cards in med carrier, along with your child's name and parent's contact info, and a copy of their med list.

The main camp number is **845-985-2291**, then ask for the Gottscho Dialysis Unit x227. The fax number for the camp dialysis unit (during sessions) is 845-985-0059.

We do our best to accommodate every child’s needs, so please let us know if you have any special concerns. We hope your child has an enjoyable experience and we rely on your assistance in these preparations. Feel free to contact us if you have questions prior to camp!

Maya Doyle, LCSW, Social Work Coordinator (347) 665 8662 mdoyle@montefiore.org
Elena Cotillo, RN, Dialysis Nurse Coordinator ecotillo@montefiore.org
Blanche Van Etten, Camp Registrar (845) 985-2291 campregistration@frostvalley.org
Ruth Gottscho Dialysis and Children’s Kidney Program at Frost Valley YMCA
www.frostvalley.org/kidney

Transfer Summary

This form must be completed and signed by child’s doctor in the month of JUNE prior to arrival at camp. Any additional paperwork, and all medications, should be carried in a separate piece of luggage and brought directly to the Wellness Center/Dialysis Unit. Meds from bus campers will be delivered to us from the buses.

Name of Camper: _________________________________________________________________________

Type of Camper:   ○ Hemo   ○ PD   ○ Transplant   ○ CKD >Stage

Kidney Diagnosis/Other Conditions: __________________________________________________________________

Allergies: ______________________________________________ _________________________________________

○ Bedwetting   ○ GU Catheterization   ○ Injectable Meds (Epogen, Insulin, Growth Hormone)

Vital Signs (date):  __________

Weight (dry)__________ Temperature _____ Blood Pressure__________ Heart Rate _____

For Dialysis: Please sign this form and complete med list. Attach transient dialysis forms, recent flow sheets, recent care plan, Montefiore dialysis consents, and recent labs. All forms available at frostvalley.org/kidney.

<table>
<thead>
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<th>Dialysis Prescription:</th>
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For CKD and Transplant: Please sign this form and complete medication list. Attach recent labs and notes detailed any recent changes, particularly rejection episodes.

Please FAX or email to camp coordinator at 718-652-3136 / mdoyle@montefiore.org

AND give family a copy to pack with 14-day supply of ALL medications

Contact us at (718) 655-1120 or (845) 985-2291 x227 if there are any acute changes in child’s condition or medications.

Notes:

Medical Clearance: It is my professional opinion that the above named child is medically stable, and suitable to participate in resident camp activities.

Name & Title: __________________________________________________________

Referring Center: ____________________________________________________

Phone Number: ______________________________________________________
Medication List

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<th>Medication Strength/Concentration</th>
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<th>Time given</th>
<th>Time given PM</th>
<th>Time given</th>
<th>Purpose</th>
<th>Notes</th>
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Additional:

Diet:

Allergies:

Home Pharmacy:______________________________________________________________

Pharmacy Phone:______________________________________________________________
Ruth Gottscho Dialysis and Children’s Kidney Program at Frost Valley YMCA
www.frostvalley.org/kidney

Reminders for Everyone

The main camp number is (845) 985-2291, then ask for the Gottscho Dialysis Unit (x227).

Medications

- Kidney campers must BRING THEIR MEDS to camp. (Do not order meds as other campers do). This includes pills, liquid medications, and any injectables (growth hormone, Epogen, insulin, etc.). Children should arrive with at least a 14-day supply of all medications, which should be in the original labelled containers from the pharmacy, NOT pre-poured.
- Children with unlabeled meds cannot stay at camp!
- We recommend packing in a separate carrier or cooler bag, labelled with their name. Include an extra copy of insurance or prescription coverage cards in the medication carrier, along with child's name and parent's contact info, and a copy of their med list.
- Medications and any related paperwork should be brought immediately to the Wellness Center or given to counselors on your child’s bus. Please doublecheck ALL meds before your child boards the bus!
- When your child returns from camp, meds will be packed in their luggage whenever possible, but please check with bus counselors for anything required special arrangements (liquids, cooler bags, etc).
- If you have any questions about bringing/transporting meds to camp, please contact our coordinators ASAP (below)

For PD campers

Please share this info with your PD nurse.
Be sure to review CAPD technique with your nurse prior to arriving at camp. Our nurses will be there to help and teach you, but training and practicing ahead of time is VERY important.

Contact your supplier (Baxter, Fresenius) several weeks ahead of time and let them know that you need: 14-16 days’ worth of dialysis fluid & supplies delivered to camp. Specifically request Ultrabags and Minicaps for CAPD! Your dialysis nurse can contact us directly to discuss supplies and routine at camp.

The address is: Ruth Gottscho Dialysis Unit/Guenther Wellness Center, Frost Valley YMCA 2000 Frost Valley Road Claryville, NY 12725-9600 Phone (845) 985-2291

Maya Doyle, LCSW, Social Work Coordinator 347-665-8662 mdoyle@montefiore.org
Elena Cotillo, RN, Dialysis Nurse Coordinator ecotillo@montefiore.org

We can’t wait to see your camper!
Kidney Program Deposit Form

Dear Parent,

A place is being reserved for your child at Frost Valley YMCA this summer. Each child attending our program receives a scholarship that is worth more than $2000 per camper. Every year, we have a waiting list of children who want to attend. Last minute cancellations and no-shows are a great loss to the program.

In order to confirm your child's attendance, please return this form with a $25 deposit (payable by credit card below, check or money order).

Please mail to:
Camp Registrar
Frost Valley YMCA
2000 Frost Valley Road
Claryville, NY 12725

This deposit will be available in the camp store for your child when they arrive at camp, so that they can purchase Frost Valley gear! You can always add extra money to your child's camp store account.

<table>
<thead>
<tr>
<th>Please find enclosed a $25 deposit for my child’s attendance at the Ruth Gottscho Dialysis and Children’s Kidney Program at Frost Valley YMCA this summer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s Name</td>
</tr>
<tr>
<td>Type of Payment (circle)</td>
</tr>
<tr>
<td>Credit Card Number</td>
</tr>
<tr>
<td>Expiration date and verification code</td>
</tr>
<tr>
<td>Signature</td>
</tr>
<tr>
<td>I authorize Frost Valley YMCA to charge the above card for $25 on receipt of this form</td>
</tr>
</tbody>
</table>

If your child is NOT able to attend, you MUST let us know two weeks prior to camp attendance or provide a doctor's note. Late notice or lack of notice means the deposit will not be refunded.

If you have any questions regarding the deposit policy, please contact camp coordinator Maya Doyle (mdoyle@montefiore.org) or you may also call the registrar’s office at 845-985-2291 to provide credit card info by phone.
CONSENT FORM
(to be signed by patient wherever applicable)

Date _________________, 20___  Time _______________ A.M./P.M.

I. PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT

1. I hereby authorize Dr. Kaskel or associates or assistants of his/her choice at Montefiore Medical Center to perform upon me/the patient named above the following operation(s) and/or procedure(s):
   PLEASE PRINT OR TYPE, USE LAY TERMINOLOGY & INDICATE LEVEL OF SPINAL SURGERY, RIGHT AND LEFT MUST BE WRITTEN IN THEIR ENTIRETY.
   hemodialysis/peritoneal dialysis

2. Dr. __________________ (home unit) has fully explained to me the nature and purposes of the operation(s) procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation(s), treatment(s) or procedure(s).

3. It has been explained to me that during the course of an operation unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) set forth in paragraph 1. I therefore authorize and request that the above named surgeon, his associates and/or assistants perform such related surgical procedures and administer whatever is necessary and desirable in the exercise of their professional judgment.

4. I further consent to the administration of such anesthesia, sedation and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health as well as benefits and alternatives associated with anesthesia, sedation and blood transfusions and these have been explained to me.

5. I further consent to disposal by hospital authorities, or possible use for research purposes, in accordance with its accustomed practice, of any tissues or parts which may be removed.

6. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

Interpreter if required

Patient/Relative or Guardian

SIGNATURE

SIGNATURE

PRINT NAME AND ADDRESS

PRINT NAME

Witness

SIGNATURE

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT

PRINT NAME

SIGNATURE

DATE SIGNED

Physician obtaining consent

SIGNATURE

PRINT NAME

DATE

II. INFORMED CONSENT DISCUSSION: I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure(s)/operation(s), and sedation and/or blood/blood products, when applicable. I have offered to answer any questions and fully answered such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Remarks: Dialysis at camp

Home Unit Physician

SIGNATURE

PRINT NAME

DATE

III. ATTENDING PHYSICIAN OPERATIVE SITE/SIDE VERIFICATION: I hereby confirm that the procedure described above, including laterality, where applicable, is correct.

Attending Physician

SIGNATURE

(To be completed on the day of surgery.)

DATE

TIME
Frost Valley/Gottscho Kidney Camp

UNIFORM ESRD TRANSIENT HEMODIALYSIS FORM

PATIENT INFORMATION

Patient Name: ___________________________ / / / Sex ___
Last                 First
DOB

Parent or Legal Guardian (If Minor)

Address: __________________________________________ Phone: (H) __________ (W) __________

SSN# __________________________ HIC# __________________________ Date of first Dialysis / / /

ESRD Diagnosis: Primary __________________ Secondary __________________

Treatment Dates Requested / / - / / Total # of Treatments __________________

Preferred Time: __________________

REFERRING DIALYSIS UNIT INFORMATION

Referring Unit Name ______________________ Phone __________________ Fax __________

Contact Nurse ________________________ Social Worker ________________________

Primary Nephrologist ______________________ Phone __________________ Fax __________

Emergency Pt. Contact Name ______________________ Relationship _________ Phone __________

LOCAL RESIDENCE INFORMATION (TRANSIENT CITY)

Local Address or Hotel ______________________ Phone __________________
Frost Valley YMCA/Ruth Gottscho Dialysis & Children's Kidney Program 845-985-2291

Emergency Contact ______________________ Relationship _________ Phone __________

Admitting Nephrologist Kaskel ______________________ Phone 718-665-1120

CURRENT TREATMENT ORDERS

------Home ------In-Center Hemo ------Self Care ------Staff Assisted

Dialyzer: ______________________ Blood Flow _______ Dialysate Flow

Treatment Type ______ Conventional ______ High Flux ______ High Efficiency ______ Volumetric ______ Yes _______ No

Times Per Week ______________________ Prescribed Time ______________________

Dialysate Rx: K+ ______ CA++ _______ Dextrose ______ Sodium _______ Bicarb _______ Acetate _______

Sodium Modeling: ______________________

Dry Weight ________ #kg #lb

Heparinization Method ______________________ Total Units ______________________

If pump, DC ______ hr/min. pretreatment termination

VASCULAR ACCESS

Vascular Access: Type ______ Location ______ Flow Direction ______

Local Anesthetic ____ Yes ____ No  Usual Venous Pressure _______ Diagram: ______

Other special cannulation considerations: i.e., needle gauge, self-cannulation

Vascular catheter special flush instructions ______________________
**PATIENT SPECIFIC INFORMATION:**

**(SYNOPSIS OF UNIQUE CHARACTERISTICS OF PATIENT’S TREATMENTS)**

**Allergies:**

Patient's trends and usual response to treatment__________________________________________

Inter dialytic wt. gains________________# kg B/P range: Pre_______Intradialytic_______Post________

Usual BP support methods________________________________________________________________

Unusual reactions or need______________________________________________________________

Special needs or circumstances relative to transient visit__________________________________

**INTRADIALYTIC MONITORING: IF APPLICABLE, OTHERWISE NOTE "N/A"**

| Special Labs ___________________________ | Blood glucose ___________________________ |
| Intradialytic treatments: Dressings____________________ | O2 ___________________________ | Other ___________________________ |
| EPO _______ Yes _______ No _______ Units _______ SQ ___________________________ | IV ___________________________ | x's/week ___________________________ |
| Calcijex _______ Yes _______ No _______ Mcg _______ X’s/Week ___________________________ |
| Intradialytic meds: (i.e., Infed)______________________________ |
| Mobility:_________Ambulatory ________ Non-Ambulatory_______ | Ambulatory with assist ___________________________ |

**Special Dietary Considerations**

Intradialytic Nutrition Orders_________________________ | Fluid Restriction_________________________

**ENCLOSURES: CHECK INDICATES INFORMATION SENT FROM HOME FACILITY**

____ Standing Orders ___________________________ | Advance Directive, if applicable ___________________________

____ Problem list (Last 6 months) ________ | Current H & P (within 1 year) ___________________________

____ Medication record (home and in-center) ________ | Hemo last 3 treatment records ___________________________

____ Most recent psycho-social evaluation ________ | Long-term care plan (current year) ___________________________

____ Patient care plan (most recent within 6 months) ________ | Most recent nutritional assessment ___________________________

____ Progress note (past 3 months to current) ________ | MD ________ RN ________ RD ________ MSW ___________________________

____ Diagnostic tests:_________EKG ________ CXR (within 2 years) ________ Laboratory profile (within last 30 days) ___________________________

____ HBsAg status ________ Positive ________ Negative ________ Date ________ / ________ / ________

____ HbsAB status ________ Positive ________ Negative ________ Date ________ / ________ / ________ | Vaccine series complete ________ Yes ________ No ___________________________

____ Insurance information, carrier name & address current copies (front & back) of the following:_________ Medicare card ________ Co-insurance card(s) ________ other (specify) ___________________________

**TRANSPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY**

____ LRD ________ Cadaver

Transplant facility name and address ___________________________

Contact Person ___________________________ | Phone ___________________________

**SPECIAL INSTRUCTIONS**

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

PATIENT IS NOT ACCEPTED UNTIL OFFICIAL NOTICE IS RECEIVED FROM RECEIVING UNIT.

Signature ___________________________ | Title ___________________________ | Date ________ / ________ / ________

(Referring unit person who completes form)
### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>[Name]</td>
</tr>
<tr>
<td>DOB</td>
<td>/ /</td>
</tr>
<tr>
<td>Sex</td>
<td>Marital Status</td>
</tr>
<tr>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>Parent or Legal Guardian (IF Minor)</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>Phone (H) (W)</td>
</tr>
<tr>
<td>SS#</td>
<td>HIC#</td>
</tr>
<tr>
<td>ESRD Diagnosis: Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Date of Arrival</td>
<td>Date of Departure</td>
</tr>
</tbody>
</table>

### LOCAL RESIDENCE INFORMATION (TRANSIENT CITY)

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Local Address or Hotel</td>
<td>Frost Valley YMCA/Ruth Gottscho Dialysis &amp; Children's Kidney Program  Phone: 845-985-2291</td>
</tr>
<tr>
<td>Emergency Contact</td>
<td>Kaskel  Phone: 718-655-1120</td>
</tr>
</tbody>
</table>

### CURRENT TREATMENT ORDERS

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>CAPD</td>
<td>CCPD</td>
</tr>
<tr>
<td>Dry Weight</td>
<td>#/kg</td>
</tr>
<tr>
<td>Type of System (or cycler)</td>
<td>Connecting System</td>
</tr>
<tr>
<td>Catheter Type</td>
<td>Episodes of peritonitis past 6 months</td>
</tr>
<tr>
<td>Peritonitis Protocol</td>
<td></td>
</tr>
<tr>
<td>Exit site care</td>
<td></td>
</tr>
<tr>
<td>Last tubing change date</td>
<td>/ /</td>
</tr>
<tr>
<td>List supply of medications patient has:</td>
<td></td>
</tr>
<tr>
<td>Self-Administers:</td>
<td>yes</td>
</tr>
<tr>
<td>Heparin</td>
<td></td>
</tr>
<tr>
<td>Antibiotic: Specify</td>
<td>Other</td>
</tr>
</tbody>
</table>

### CAPD - Camp Prescription

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exchange Volume</td>
<td>Dialysate</td>
</tr>
<tr>
<td>Exchanges per day</td>
<td></td>
</tr>
</tbody>
</table>

### CCPD - Home Prescription

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td># Cycles</td>
<td>Night Volume</td>
</tr>
<tr>
<td>Day Volume</td>
<td>Total volume</td>
</tr>
<tr>
<td>Fill time</td>
<td>Dwell time</td>
</tr>
</tbody>
</table>
**PATIENT SPECIFIC INFORMATION:**
(SYNOPSIS OF UNIQUE CHARACTERISTICS OF PATIENT'S TREATMENTS)

Allergies: ____________________________________________
Unusual reactions or needs: ________________________________

Average B/P: _______ Mobility: _______ Ambulatory _______ Non-Ambulatory _______ Ambulatory with assist _______

Special needs or circumstances relative to transient visit: _______________________________________________________

Vascular access: ____ Yes____ No ____ Type: __________________________ Location: ____________________________

**SPECIAL DIETARY CONSIDERATIONS**

________________________________________________________________________
________________________________________________________________________

Fluid Restriction____________________________

**ENCLOSURES: CHECK INDICATES INFORMATION SENT FROM HOME FACILITY**

__Standing orders __Advance Directive, if applicable
__Problem list (Last six months) __Current H&P (within 1 year)
__Medication record (home and in-center) __PD last 3 clinic records
__Most recent psycho-social evaluation __Long term care plan (current year)
__Patient care plan (most recent within 6 months) __Most recent nutritional assessment
__Copy of RX supply __Copy of self EPO training sheet
__Progress note (past 3 months to current) MD RN RD MSW

Diagnostic tests EKG CXR (within 2 years) Laboratory profile (within last 30 days)

__HbsAg status: Positive Negative Date / / Vaccine Series Complete: yes no
__HbsAB status: Positive Negative Date / / __

__Insurance information, carrier name & address current copies (front & back) of the following
__Medicare card Co-insurance card(s) Other (specify)

__Method T __

**TRANPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY**

LRD _____ Cadaver
Transplant facility name and address ________________________________________________________________

Contact Person: __________________________ Phone: ____________________________

**SPECIAL INSTRUCTIONS**

________________________________________________________________________
________________________________________________________________________

PATIENT IS NOT ACCEPTED UNTIL OFFICIAL NOTICE IS RECEIVED FROM RECEIVING UNIT.

Signature: __________________________ Title: __________________________ Date: __ / __
(Referring unit person who completes form)
**Ruth Gottscho Dialysis and Children’s Kidney Program at Frost Valley YMCA**

[www.frostvalley.org/kidney](http://www.frostvalley.org/kidney)

**Reminders for Everyone**

The main camp number is **(845) 985-2291**, then ask for the Gottscho Dialysis Unit (x227).

**Medications**

- Kidney campers must **BRING THEIR MEDS** to camp. (Do not order meds as other campers do). This includes pills, liquid medications, and any injectables (growth hormone, Epogen, insulin, etc.). Children should arrive with at least a 14-day supply of all medications, which should be in the original labelled containers from the pharmacy, NOT pre-poured.
- Children with unlabeled meds cannot stay at camp!
- We recommend packing in a separate carrier or cooler bag, labelled with their name.
- Medications and any related paperwork should be brought immediately to the Wellness Center or given to counselors on your child’s bus. Please double check ALL meds before your child boards the bus!
- When your child returns from camp, meds will be packed in their luggage whenever possible, but please check with bus counselors for anything required special arrangements (liquids, cooler bags, etc).
- If you have any questions about bringing/transporting meds to camp, please contact our coordinators ASAP (below)

**For PD campers**

Please share this info with your PD nurse.

Be sure to review **CAPD** technique with your nurse prior to arriving at camp. Our nurses will be there to help and teach you, but training and practicing ahead of time is VERY important.

Contact your supplier (Baxter, Fresenius) several weeks ahead of time and let them know that you need: 14-16 days’ worth of dialysis fluid & supplies delivered to camp. Specifically request Ultrabags and Minicaps for CAPD! Your dialysis nurse can contact us directly to discuss supplies and routine at camp.

The address is: Ruth Gottscho Dialysis Unit/Guenther Wellness Center, Frost Valley YMCA 2000 Frost Valley Road Claryville, NY 12725-9600 Phone (845) 985-2291

Maya Doyle, LCSW, Social Work Coordinator  347-665-8662  mdoyle@montefiore.org
Elena Cotillo, RN, Dialysis Nurse Coordinator  ecotillo@montefiore.org

**We can’t wait to see your camper!**
Dear Summer Camp Families,

We are excitedly planning for Summer Camp 2022 and wanted to share with you some important information regarding next summer.

After many conversations with our CEO, Senior Administration and our Staff, Frost Valley has made the decision that all eligible overnight and day campers (ages 5 and up) and staff will be required to be fully vaccinated against Covid-19 to attend camp this summer with the only exception being those who are medically exempt from receiving the vaccination. To be considered fully vaccinated you must have received both doses of the 2-dose series of the vaccine at least 2 weeks before arriving at camp. Vaccinations must be uploaded to the camper's health form before arriving or must show proof of vaccination upon arrival. Campers who are medically exempt must provide a letter from their physician. If you have any questions, please reach out to our Wellness Center at wellness@frostvalley.org.

As we continue to plan for next summer, we are consistently looking at our Covid-19 protocols and guidelines from last summer and making adjustments where necessary. We are monitoring what the CDC, American Camp Association, and Department of Health at the local and state levels are recommending as we make decisions to ensure the health and safety of our campers and staff.

If you have any questions, please don’t hesitate to reach out to the appropriate person listed below.

Best,
The Summer Camp Team

Zach Eigenbrodt (zeigenbrodt@frostvalley.org) - Resident Camp and Adventure program
Katie Taylor (ktaylor@frostvalley.org) - Farm Camp, EVR, and Horse Trails
Jessie Emmons (jemmons@frostvalley.org) - Mustang and Durango