Guidelines for Academic Camps and Clinics at A-State

Seek approval for new and/or continuing camps from appropriate Chair or Dean.

1. Budget Process – Unless subsidized by a grant, camps/clinics must be self-supportive (operated by revenue generated by the camp, i.e. camp registration fees).
   a. Camp may be operated through an existing department account.
   b. Camp may be operated through a grant account
      i. Contact the Office of Sponsored Programs Accounting at 972-2400 to ensure that all requirements are met with respect to expending funds, meeting documentation requirements, etc.
   c. Camp may require a separate ‘camp account’ be established
      i. Contact the Controller’s Office at 972-2024 and the Budget Office at 972-3700 to request this.

2. Risk Management - the Office of Risk Management should be contacted for completion of appropriate risk management forms and additional considerations. Contact Information: Telephone 972-2309; e-mail risk@astate.edu
   a. Forms – these forms are attached
      i. Liability Waivers – Must be completed by camp attendees’ parents or legal guardians and kept on file for five (5) years.
      ii. Medical Release Forms - Must be completed by camp attendees’ parents or legal guardians and kept on file for five (5) years.
   b. Additional Considerations
      i. Accidents, Injuries and Illness of Camp Attendees: Camp Directors and camp staff/volunteers should understand and effectively communicate the university’s position on accidents, injuries and illnesses of camp attendees. This statement should be posted on camp websites and registration pages, printed in brochures, etc. “Certain risks of personal physical injury, property damage or other losses exist with respect to participation in camps/clinics/ workshops, etc. Participants must assume all risks of any such personal injuries, property damages, or other losses that participant may sustain as a result of participation in said events. Arkansas State University does not assume responsibility for payment of ambulance services, emergency room fees, prescriptions, or any other medical treatment.”
      ii. Compliance with the university’s Child Maltreatment Policy, Affirmative Action Policy, and Title IV Procedures. Contact the Assistant Vice
Chancellor for Human Resources at 972-3454 for required information and training for all camp staff/volunteers.

1. AS SOON AS POSSIBLE prior to the start of the camp, Camp Directors should provide a list of camp staff/volunteers.
2. All camp staff and volunteers must complete a background check prior to the start of the camp through the online request form http://www.astate.edu/a/hr/files/background-check-form.dot.

iii. Suggested Minimum Staff/Camp Participant Ratios

**Ratios of staff on duty with program participants** in units or living groups and, in general, program activities are:

<table>
<thead>
<tr>
<th>Age of Participants</th>
<th>Staff</th>
<th>Overnight</th>
<th>Day-Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-5 years</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6-8 years</td>
<td>1</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>9-14 years</td>
<td>1</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>15-18 years</td>
<td>1</td>
<td>10</td>
<td>12</td>
</tr>
</tbody>
</table>

iv. Accident Documentation and Reporting. In the event of an accident or incident, the attached incident report should be completed and returned to the Office of Risk Management within the Office of Finance and Administration.

v. Emergency Medical Procedures. In the event of an emergency, the university’s emergency medical procedures, policy number 03-01, should be followed. These procedures are attached and can be found on the university’s website at http://www.astate.edu/dotAsset/fecb9916-e2a3-43ba-abed-b78a4b9fdd91.pdf

vi. Other Possible Risk Management Concerns specific to your camp activities (example: transporting camp attendees) may be addressed by contacting the Office of Risk Management.

3. Residence Life should be contacted for information about housing availability and related costs for over-night camps. The residence life event coordinator may be reached at 680-4073 and information is available on-line at http://www.astate.edu/a/residence-life/camps/

4. Dining Services should be contacted for information about camp meals for your camp. Dining Services can be reached by 972-2059. Information about camps and to fill out the brochure online can be done at http://www.astate.edu/a/dining/ and email it to Mcobbs@astate.edu.
5. Parking Services should be contacted at 972-2945 to address any parking concerns for camp participants, staff, sponsors or spectators. Information about event parking is also available on line at http://www.astate.edu/a/parking/event-parking/

6. The University Police Department should be notified of the dates/times of your camp/clinic, as well as where your activities will be held on campus. UPD can be reached at 972-2093 and an ‘Event Notification’ form can be completed on-line at http://www.astate.edu/police.
Approval Form for New Academic Camps/Clinics

Faculty Submitting Camp/Clinic Proposal: ____________________________________________

  Are you teaching or conducting research during the semester camp is offered?
  YES _________ NO _________

  Do you plan to be compensated for directing the camp?
  If YES, how much? ______________________ NO _________

Proposed Dates of Camp/Clinic: _________________________________________

Name of Camp: (ex. Art Camp) _________________________________________

Purpose of Camp: (ex. Instruction in mixed media art projects designed for school age children)

________________________________________

Will camp/clinic participants stay on campus overnight? YES _________ NO _________

Age Group of Camp Attendees: ________________________________

Number of Attendees Expected: __________________________

Amount of Registration Fee: __________________________

Anticipated Total Revenue: __________________________

Anticipated Total Expenses: __________________________

Camp Evaluation Method (how will you access the effectiveness of this camp, e.g., faculty, student and/or parent evaluation forms).

________________________________________

________________________________________

________________________________________

________________________________________

Other information to be considered when approving this request:

Signature of Faculty Making Request / Date

Chair of your Department / Date

Dean of your College / Date

You may choose to notify Beverly Gilbert once your Chair and Dean have approved at
c@astate.edu; or bboals@astate.edu if you would like to be included in the overall marketing
for the Summer Camp Academy; or call 8358 for information on documentation and record-
keeping. Assistance with registration, marketing, etc. is optional. Your department or college
may choose to be responsible for all aspects of your camp.
Risk Management Forms and Information
RELEASE OF ALL CLAIMS FOR PERSONAL INJURY AND PROPERTY DAMAGE

PARENT OR LEGAL GUARDIAN CONSENT (for minor participants)
FOR PARTICIPATION IN
ARKANSAS STATE UNIVERSITY EVENTS

As the parent or legal guardian of ____________________________, I give my
consent and approval for ____________________________ to participate in ____________________________
EVENT NAME
on ____________________________, at ____________________________
EVENT DATES Location

I recognize and acknowledge that certain risks of personal physical injury,
property damage, or other losses exist with respect to participation in this
event and further agree to:

Assume all risks of any such personal injuries, property damages, or other losses
that participant may sustain as a result of participation in this event.

Fully release and discharge Arkansas State University, its officers, agents and
employees from any and all claims from personal injuries, property damages or
other loss that participant may suffer on account of participation in said event.

Indemnify and hold harmless Arkansas State University, its officers, agents and
employees from all claims, suits, actions, injuries, damages, and losses sustained
by participant and arising out of, connected with, or in any way associated with
participant’s participation in said event.

I HAVE FULLY READ AND UNDERSTAND THE FOREGOING.

_____________________________________
Name of Parent or Legal Guardian (Print)

_____________________________________
Signature of Parent or Legal Guardian

Date ________________________________
RELEASE OF ALL CLAIMS FOR PERSONAL INJURY AND PROPERTY DAMAGE

ARKANSAS STATE UNIVERSITY EVENTS
(for participants ages 18 and over)

I ________________________________, have chosen to participate in

(Participant’s Name)

__________________________________________
(EVENT NAME)

on ________________________________, at ________________________________
(EVENT DATES) (Location)

I recognize and acknowledge that certain risks of personal physical injury, property damage, or other losses exist with respect to participation in this event and further agree to:

Assume all risks of any such personal injuries, property damages, or other losses that participant may sustain as a result of participation in this event.

Fully release and discharge Arkansas State University, its officers, agents and employees from any and all claims from personal injuries, property damages or other loss that participant may suffer on account of participation in said event.

Indemnify and hold harmless Arkansas State University, its officers, agents and employees from all claims, suits, actions, injuries, damages, and losses sustained by participant and arising out of, connected with, or in any way associated with participant’s participation in said event.

I HAVE FULLY READ AND UNDERSTAND THE FOREGOING.

________________________________________________________________________
Name (Print)

________________________________________________________________________
Signature

Date ________________________________
ASU Camp Medicine Information and Consent to Self-Administration Form

Camper’s Name: _________________________________

Parent/Guardian Name/Address/ Contact Numbers:

________________________________________________________________

________________________________________________________________

Camper Allergies if any: _____________________________________________

My camper takes the following medications and is authorized to self-administer those medications. If none, indicate NONE below.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage Amount</th>
<th>How often?</th>
<th>Expected Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Arkansas State University will not provide nor administer any medications to campers without first obtaining consent of the parent/guardian.

Please provide any additional information we should know regarding your child’s medication or medical condition: ________________________________

________________________________________________________________

________________________________________________________________

Parent/Guardian Signature: ___________________________ Date: __________
THE AUTHORIZATION TO TREAT AND FOR RELEASE OF HEALTH RECORDS OR INFORMATION CONTAINED ON THE OPPOSITE SIDE OF THIS CONSENT (or as additional page) MUST BE EXECUTED.
Authorization to Treat and for Release of Health Records or Information

SECTION A: As the parent or legal guardian of the student/patient identified below, who is a minor attending camp at Arkansas State University, I hereby authorize Arkansas State University, hereinafter referred to as the health care provider, to arrange for medical treatment to the minor should such medical care be deemed necessary by camp personnel. I further authorize Arkansas State University to disclose the minor’s personal health information to the persons or entities named below. I understand this authorization is voluntary and made to confirm my directions regarding treatment of the minor and release of his or her personal health information.

Student/Patient Name: ____________________________________________
Address: _______________________________________________________
Telephone: ___________________ Health Record Number (if any): __________
Social Security Number: ___________________ Date of Birth: _______________

SECTION B: Personal Health Information to be Disclosed: Specifically and meaningfully describe the personal health information you are authorizing to be used and/or disclosed:

Any and all personal health information within the possession of the health care provider.

Persons/Entities Authorized to Receive and Use: Name or specifically describe the persons and/or entities to whom you are authorizing the above medical care provider to disclose or let use the personal health information described above:

All medical care providers giving medical services to my minor child or ward.

Purpose of the Disclosure: The disclosure is being made to assist in the provision of medical care to my minor child or ward while he or she is participating in a camp at Arkansas State University.

Right to Revoke: I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the above named medical care provider. I understand the revocation will not apply to medical care which has already been rendered or information that has already been released in response to this authorization.

Voluntary Authorization: I understand that authorizing the medical care and disclosure of the personal health information is voluntary. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. This authorization will expire two (2) years from the date below.

SIGNATURE:

I, ________________________________________, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my directions to the health care provider. I understand that, by signing this form, I am confirming my authorization that the health care provider may arrange for medical care to be provided to my minor child or ward and disclose to the persons named in this form the nonpublic personal health information described in this form.

Signature: ________________________________ Date: __________________________

Relationship to Individual: __________________________

Witness: ___________________________________
Regarding accidents, injuries and illness of camp/clinic attendees:

“Certain risks of personal physical injury, property damage or other losses exist with respect to participation in camps/clinics/ workshops, etc. Participants must assume all risks of any such personal injuries, property damages, or other losses that participant may sustain as a result of participation in said events. Arkansas State University does not assume responsibility for payment of ambulance services, emergency room fees, prescriptions, or any other medical treatment.”
### RECOMMENDED STAFF/ATTENDEE RATIONS

#### DAY GUESTS

<table>
<thead>
<tr>
<th>AGE</th>
<th>STAFF</th>
<th>NUMBER OF CAMPERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-5</td>
<td>to</td>
<td>6</td>
</tr>
<tr>
<td>6-8</td>
<td>to</td>
<td>8</td>
</tr>
<tr>
<td>9-14</td>
<td>to</td>
<td>10</td>
</tr>
<tr>
<td>15-17</td>
<td>to</td>
<td>12</td>
</tr>
</tbody>
</table>

#### OVERNIGHT GUESTS

<table>
<thead>
<tr>
<th>AGE</th>
<th>STAFF</th>
<th>NUMBER OF CAMPERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-5</td>
<td>to</td>
<td>5</td>
</tr>
<tr>
<td>6-8</td>
<td>to</td>
<td>6</td>
</tr>
<tr>
<td>9-14</td>
<td>to</td>
<td>8</td>
</tr>
<tr>
<td>15-17</td>
<td>to</td>
<td>10</td>
</tr>
</tbody>
</table>

American Camp Association  
Safety, staffing, training, emergency procedures, and camp risk management  
[www.acacamps.org](http://www.acacamps.org)
ARUBAS AS TATE UNIVERSITY - ACCIDENT REPORT FORM (Non-employee)

Injured Party Information:

Status: _____ Student  _____ Visitor  _____ Other

Name: __________________________________________________________ Phone #: __________________________________________

Address: ____________________________________________________ City/State/Zip: ______________________________________

ASU Student ID: ____________________________________________ If Visitor or Other: D.L. No. ____________________________

Description of Accident

Date and Time of Accident: _________________________________

Location of Accident: ______________________________________

Nature of Injury:

Asphyxiation __  Burn __  Laceration/Cut __  Other (specify): ________________

Amputation __  Concussion __  Poisoning __ ________________________________

Abrasion __  Dislocation __  Puncture __ ________________________________

Bite __  Fainting __  Shock __ __________________________________________

Bruise __  Fracture __  Sprain/Strain __ ________________________________

Part of Body Injured:

Abdomen __  Ear __  Hand __  Mouth __  Other (specify): ________________

Ankle __  Elbow __  Head __  Neck __ ______________________________________

Arm __  Eye __  Hip __  Nose __ __________________________________________

Back __  Finger __  Knee __  Shoulder __ ________________________________

Chest __  Foot __  Leg __  Teeth __ ______________________________________

How did the accident happen? What was the individual doing? List specific activity or conditions that led to the accident.

____________________________________________________________________

____________________________________________________________________

Witnesses:

Name: __________________________________________________________ Phone: __________________________

Address: ______________________________________________________ Phone: __________________________

Witness Statement: ______________________________________________ Phone: __________________________

____________________________________________________________________

Immediote Action Taken:

Ambulance Called: _____  Transferred to Hospital: _____  If yes, which hospital: ________________________________

Transferred to Student Health Center _____  by: ______________________________________________________________

Referred to Student Health Center: _____  Other: ____________________________________________________________

ASU Employee Completing Report (print name/department): ________________________________

Signature: __________________________  Date: __________________________

THIS DOCUMENT MUST BE SUBMITTED TO THE Office of Finance & Administration
The purpose of this guideline is to establish procedures to be followed whenever a medical emergency exists on University property. A medical emergency may be defined as an urgent need for assistance or relief.

**A Life Threatening Medical Emergency** exists when an individual is:

1. Unresponsive
2. Difficulty breathing
3. Chest pain
4. Profuse bleeding
5. Seizure
6. Other serious bodily injury

If you are assisting in an emergency situation, follow these procedures:

**If individual is unresponsive:**

1. Call 9-911
2. Identify yourself
3. Provide building name, floor number and room number
4. Provide type of emergency
5. Call University Police Department at 972-2093
6. Assess the client's breathing. This can be done quickly by looking at the rising and falling of the chest.
7. Tap the client's shoulder and ask, "Are you OK?" to judge responsiveness.
8. If not breathing, or having difficulty breathing, position head in a neutral, slightly tilted back position.
9. Assess pulse. If there is no pulse and the client is not breathing, start CPR. (IT IS RECOMMENDED THAT FACULTY AND STAFF SEEK CPR CERTIFICATION.) Contact EH&S at 972-2862 to inquire about certification.
10. Remain with the individual until emergency personnel arrive.
11. Do not attempt to move the individual unless there is a possibility of additional danger.

Continued on next page…
If individual is responsive: (answers questions and able to make rational decisions)

1. Call 9-911
2. Identify yourself
3. Provide building name, floor number and room number
4. Provide type of emergency
5. Call the University Police Department at 972-2093
6. Let him/her decide whether or not to be transported by the ambulance.
7. Encourage the individual to seek treatment from their health care provider.

NOTE: Arkansas State University does not assume responsibility for payment of ambulance services, emergency room fees, prescriptions, or any other medical treatment.

Always care for the one in need as you would want to be cared for.

All accidents must be reported to the Environmental Health and Safety Department at 972-2862 and to the University Police at 972-2093. An accident report form should be completed and sent to Environmental Health and Safety.

Adopted by President’s Council December 18, 1995.

Reviewed on 5/16/13.