Staff Handbook

About This Manual

The purpose of this manual is to provide Camp Promise staff members with information and training needed in order to do an exceptional job working in the camp community this summer. Camp Promise reserves the right to change or supplement these policies and guidelines at any time without notice. Camp Directors approval will make such changes effective immediately and Camp Directors will inform employees of such changes.

Please read through this manual completely and familiarize yourself with the policies, procedures, and other useful information that it contains. All Camp Promise staff members are responsible for the entire content of this manual.

Any questions or concerns related to the content of this manual or the implementation of policies and procedures should be brought to the attention of the Camp Director.

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About Camp Promise

Mission

The mission of Camp Promise is to provide a barrier-free, weeklong overnight camp for kids, teens, and adults with muscular dystrophy or select neuromuscular diseases—regardless of age, capability, or ability to pay. We are committed to providing Camp Promise in a professional, safe, and respectful environment with a leadership team, trained volunteers, and licensed medical staff to support the needs of each and every camper.

Vision

We seek to:

- Create a welcoming community where campers learn from and support each other, fostering new and lasting friendships that extend beyond camp.
- Provide camper-focused programming that builds independence, confidence, and life skills through traditional camp activities and by bringing campers new experiences through adaptation, technology, creativity, and special guests.

Values

Professionalism. We provide a professional camp experience. We are committed to delivering a professional camp program, complete with well-trained staff and clean, accessible facilities that meet the highest of standards. We expect all staff and campers to exhibit professionalism at all times.

Integrity. We conduct all camp business ethically and with a commitment to moral integrity. We expect our entire camp community to hold high moral and ethical standards.

Respect. We respect one another and value the diversity, uniqueness and dignity of each individual within our camp community.

Independence. We promote and foster independence. We believe in greater independence for all people with disabilities, and continually seek to create opportunities that will enhance the independence of our campers.

Growth. We encourage campers and staff to grow personally and professionally. We are in the business of "people development" and we empower everyone to reach their full potential, to stretch for things they never thought possible by taking risks and expanding their comfort zones.

Guiding Principles

Safety comes first. We take safety very seriously and expect everyone on our team to do so as well. The physical, emotional, social, and medical safety of our entire camp community is of utmost priority and informs all of our plans, actions and decisions.

Camp is a launch pad. We believe camp is a stepping stone on our campers' journeys to success. It may be the best week of their summer, or the best week of their year, but we don't intend it to be the peak week of their life. Our programs and activities are intentionally designed to deliver social skills, as well as hard and soft skills, that will set them up for future success.

Say "Yes!" We strive to make anything and everything possible at camp. Whether it's ziplining with a ventilator, designing an elaborate costume for a dance, or scheming pranks, our staff are here to provide the safety, space, creativity, and energy to give our campers as many opportunities to participate as possible.

Campers come first. Everything at camp is camper-oriented. From serving campers first at mealtimes to letting them be first in line at activities, we are intentional about putting our campers' needs first at all times.

Teamwork. We are better together. We work, learn, and grow as a team. We support each other and think of our team before ourselves. We function in an efficient, ethical and professional manner using our diverse backgrounds, experience, knowledge and skills.

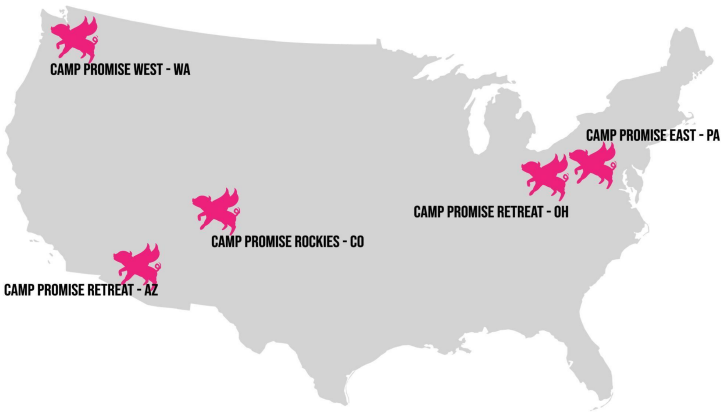
Innovation. We strive to provide new, creative, and innovative experiences for campers. Instead of limiting our thinking by starting with "what activities are already accessible", we start the conversation by asking our campers what they're interested in, and then take it upon ourselves to create and innovate new and accessible activities.

Passion in all we do. We are driven by passion, and this energy is present in all we do. Our passion is a powerful and inspiring force that encourages us to give 110% in all we do.

History

Camp Promise, a program of the Jett Foundation, started in 2009 when many summer camps were closed due to the H1N1 (aka “swine flu”) outbreak. These cancellations were last-minute, swift, and nationwide, leaving many would-be campers (and volunteers) without a camp option that summer. Partnering with the Jett Foundation, volunteers put together a weeklong, overnight, replacement program called Camp Promise-West. In its inaugural summer, Camp Promise welcomed 27 campers and 35 volunteers to camp in Vaughn, WA.

Since then, Camp Promise has grown in size and location. In 2012, Camp Promise expanded to the East coast, opening Camp Promise-East in New England. In 2015, Camp Promise opened its third site, Camp Promise-Rockies in Colorado. New for the 2022 season will be our Camp Promise Retreats in Arizona and Ohio, made specifically for our campers 18 and older.



The Jett Foundation is a 501(c)(3) organization, and the Camp Promise program relies on the generosity of donors, supporters, volunteers, foundations and individuals to meet its mission.

What makes Camp Promise special?
Camp Promise remains the only camp in the United States exclusively for individuals of all ages with muscular dystrophy or select neuromuscular diseases. All of our facilities are wheelchair accessible and staffed by highly trained volunteers and a complete medical team. Thanks to its generous supporters and a full staff of volunteers, Camp Promise is provided free-of-charge to all campers.

Here are just a few ways in which Camp Promise is unique:

1. No upper age limit. While many camps have age cutoffs, Camp Promise welcomes kids, teens, and adults with eligible diagnoses. This allows campers to continue coming to camp even in adulthood.
2. No geographical restrictions. Campers and volunteers come from all over the country and eligibility doesn't depend on one's state of residence.***At this time, to attend the AZ. or OH. 18+ Retreats, camper must reside within the respective state.**
3. Constantly evolving programming. Camp Promise has its staples, its oldies and its favorites, but each camp session mixes it up with new and exciting activities for everyone.
4. Transition Program. Camp Promise provides special age-appropriate programming geared towards older campers (16+) to promote independence and life skill development for those transitioning to adulthood.
5. We are volunteers. While we may call them "staff," counselors, and members of our medical, program, kitchen, and logistics teams all donate their time to camp.
6. One-on-one counselors. Camp Promise offers a 1:1 camper-to-counselor ratio so that each camper can have his or her own counselor to assist with activities of daily living and engagement in all camp activities.

Who We Serve

Camp Promise serves male and female campers who are six years of age or older who have muscular dystrophy or a similar neuromuscular disorder, including but not limited to:

- Acid maltase deficiency (Pompe disease, Glycogen Storage Disease)
- Ataxia Telangiectasia (AT)
- Becker muscular dystrophy (BMD)
- Charcot-Marie-Tooth disease (CMT)
- Congenital muscular dystrophy (CMD)
- Duchenne muscular dystrophy (DMD)
- Friedreich's Ataxia (FAR)
- Limb-girdle muscular dystrophy (LGMD)
- Myotonic muscular dystrophy (DM)
- Spinal muscular atrophy (SMA)

This list is not exhaustive, so please contact the camp office with specific questions about qualifying diagnoses and camper eligibility. While Camp Promise would love to accept every camper who applies, space is limited. We prioritize campers who are unable to attend any other camps. All applications are reviewed and considered by the Camp Directors.

For more information on the specific diagnoses, characteristics, and implications for recreation, please see the What Are Neuromuscular Diseases section of this handbook.

Our Logo

Our pink flying pig, also known as Pigasus, tells a story and represents three important aspects of Camp Promise.

1. Pigasus is a visual representation of how Camp Promise initially came to be. The 2009 outbreak of H1N1 flu, also known as “swine flu,” forced the cancellation of many camps. As a result, the Camp Promise logo represents its inaugural summer of camp when pigs flew.
2. Between the initial conception of Camp Promise and the first week of camp, there were only six short weeks to find a wheelchair accessible facility, fundraise $16,000, recruit volunteers and campers, and plan a week’s worth of camp activities. Given this daunting task, many doubted the program would ever get off the ground. Our logo symbolizes the magical efforts that delivered our inaugural session of camp in 2009, when the odds of pulling off camp seemed as likely as when pigs fly.
3. Our logo also illustrates Camp Promise’s continued commitment and ability to make the impossible happen for our campers. We take it upon ourselves to adapt experiences to our campers needs, and whether it is bringing wheelchair accessible hot air balloon rides to campers or outfitting their wheelchairs with a themed costume, no task is too small, no request too challenging. At Camp Promise, we embrace challenges and our goal is to achieve the things to which most people would say “when pigs fly.”

In these three ways, Pigasus symbolizes where Camp Promise came from and where it is going.

Organization

Roles & Responsibilities

The first responsibility of every staff member is to ensure the basic needs of each camper are met:

1. Safety
2. Shelter, food, clothing, and hygiene
3. Acceptance and affection
4. Recognition
5. A feeling of accomplishment

Beyond this, there are specific roles assigned to designated individuals at camp.

Camp Directors. The Camp Directors are responsible for all aspects of the Camp Promise program, including camper recruitment, placement and overall care; staff hiring, training, and supervision; camp programming, facilities liaising, and fiscal accountability.The Camp Directors also coordinate the management of day-to- day programming during the summer camp season.

Unit Leaders. Unit Leaders are responsible for creating a safe, healthy, and fun space for the members of the cabin. Unit Leaders are responsible for supervising the campers and counselors in their cabin, assisting counselors with providing personal care to their campers, leading the cabin in daily activities, coordinating their cabin's schedule of activities, and being a resource to campers and counselors at all times.

1:1 Counselors. 1:1 Counselors work one-on-one with their camper for the duration of the camp session. As the staff most immediately responsible for the health and well-being of each camper, our 1:1 Counselors work in a team to provide constant supervision and care of their assigned campers. They assist with the personal care needs of their and others' campers, including but limited to, feeding, bathing, toileting, dressing, transfers, personal hygiene, and keeping track of belongings. They work to ensure that all campers are actively participating in camp activities, they guide campers in their personal growth and acquisition of independence, and they enthusiastically support the Program Team in their daytime and evening programs.

Float Counselors. Float Counselors are assigned to a specific cabin and are responsible for working with all of the campers in their cabin. They assist other 1:1 Counselors with the personal care needs of their campers, including but limited to, feeding, bathing, toileting, dressing, transfers, personal hygiene, and keeping track of belongings. They also are responsible for providing coverage when other staff are on break. Float Counselors also work to ensure that all campers are actively participating in camp activities, guiding campers in their personal growth and acquisition of independence, and they enthusiastically support the Program Team in their daytime and evening programs.

Camp Nurse(s). Our nurses are responsible for providing routine medical care, first aid, and medication distribution at camp. They serve on our Medical Team and assist in maintaining a healthy and safe environment at camp. They will discuss health and safety procedures with staff and need to be informed of all medical issues, no matter how small, which affect a camper or staff member.

Respiratory Therapist(s). The Respiratory Therapist is responsible for maintaining and supporting the respiratory health of our campers. S/he serves on our Medical Team and works in partnership with other Medical Team members, such as the Camp Nurse(s). S/he is responsible for managing campers' respiratory equipment such as sip & puffs, bi-paps, trachs, etc., and needs to be informed of all respiratory concerns and equipment issues—no matter how small—that affect a camper or staff.

Program Team. The Program Team is composed of activity instructors who lead programs in areas such as arts and crafts, sports, science, nature, fishing, swimming (lifeguards), boating, evening programs, and electives. The camp photographer, yearbook editor, and videographer are also members of the Program team. Members of the Program Team are responsible for planning, preparing, and implementing all activities.

Logistics Team. The Logistics Team is essential to making sure our camp activities run smoothly, safely, and on-time. In the background, at all hours of the day, these individuals stay one step ahead and one step behind camp, planning and coordinating the setup and take-down of camp activities, cabin needs, and camp maintenance.

Our Expectations

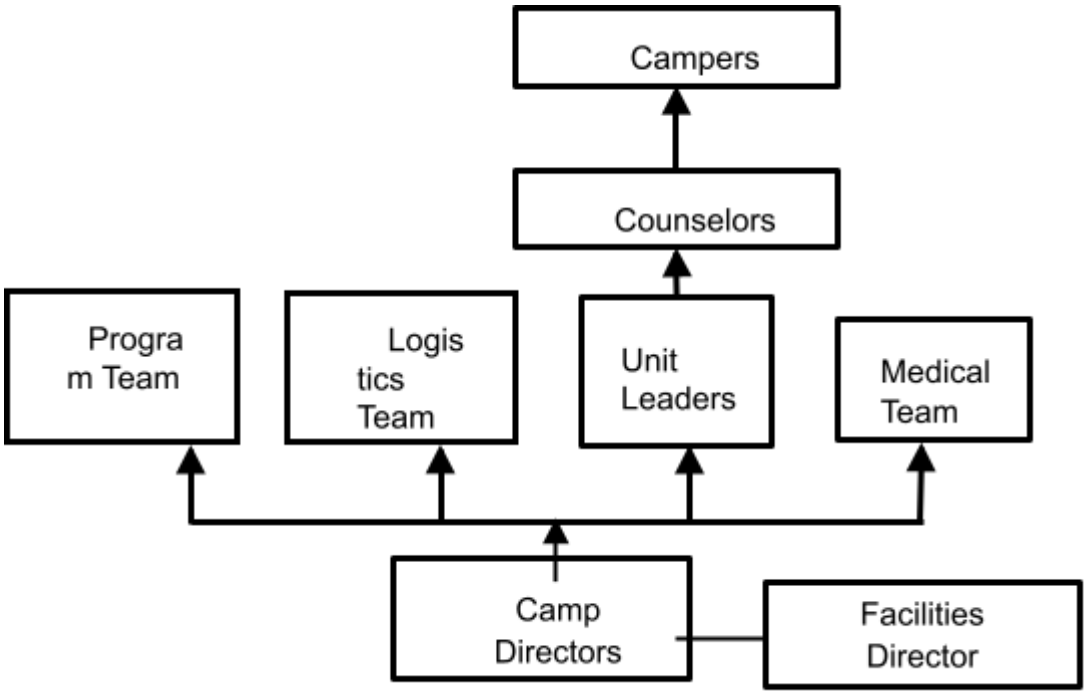
In addition to each individual's role at camp, we expect the community of leadership staff, staff, counselors, interns, and general volunteers to meet Camp Promise's mission and vision, and to exhibit the organization's values and guiding principles. Everyone is expected to respect their fellow staff members, to be flexible in working outside of their primary areas of responsibility, and to put the needs of the campers above their own needs.

All staff members are also expected to assist with cleaning and housekeeping duties as assigned by the Camp Directors.

It is also expected that staff act in the best interest of Camp Promise. All staff represent Camp Promise in their words and actions when at camp, representing Camp Promise off site (including resource fairs, fundraisers, etc.), while associating (formally and informally) with friends and family who know of their affiliation, and while wearing Camp Promise apparel. It is imperative to the mission of Camp Promise that staff present themselves in ways that are professional, service-focused, family-centered, and respectful at all times. Camp Promise asks that you refrain from engaging in any activity or behavior that could reflect unfavorably on yourself or on Camp Promise. Staff are asked specifically to consider how photos and information of themselves may be shared on the Internet. Any violation of demonstration of these characteristics, whether in person, on the Internet, or otherwise may result in disciplinary action.

Organizational Chart

At Camp Promise, we report to our campers. They are our reason for being, everyone's utmost priority, and we take our cues from them. Therefore, we intentionally put our campers at the top of our organizational chart. This means that all staff will report to the role that is below your position.



Hiring Policies

Volunteer at Will

At Camp Promise, we value all staff and hope you have a rewarding summer volunteering with us. However, all positions with Camp Promise are “at-will” and your position may be terminated with or without cause at any time at the option of either Camp Promise or yourself. Nothing in this handbook should be taken to establish or imply a contract of appointment or a guarantee of continued appointment.

Not only are there impressionable campers at each camp session watching our every move, but how we interact with each other, carry ourselves, what we wear, how we care for ourselves and each other, all help to create our Camp Promise culture. It is up to us to ensure that our actions are aligned with safety, fun, and respect

Minor violations that may require corrective measures or in extreme cases or when they occur regularly, dismissal, include:

- Tardiness or absenteeism
- Unsatisfactory job performance
- Defacing property
- Interfering with others’ ability to perform
- And others per the discretion of organization management

Major violations are serious infractions that may preclude continued appointment, and include, but are not limited to the following (at the discretion of organization management):

- Repeated occurrence of minor violations.
- Fighting behavior.
- Harassment and/or bullying of any kind to other staff members or campers.
- Any act endangering the physical and/or emotional safety of others, including employees, volunteers, and campers.
- Bringing firearms, weapons, or equipment the average individual would consider to be dangerous onto the property.
- Deliberately stealing, destroying, abusing, or damaging the rental facility or Camp Promise property, including that owned by the facility, other staff, campers, or others onsite or at off site functions.
- Knowingly or deliberately acting outside of the best interest of Camp Promise.
- Inappropriate disclosure of any confidential information about Camp Promise, its campers, its staff or volunteers, or any other confidential information.
- Willfully disregarding organization policies or procedures.
- Willfully falsifying any organizational record (e.g., signing for another staff member).
- Abuse, neglect or exploitation of campers.
- Sexual harassment.

- Use of drugs or alcohol during your camp session.
- Extreme insubordination.
- Gross neglect of duties

Non-Discrimination Policy

Camp Promise is committed to the principle of equal employment opportunity. Applicants for positions at Camp Promise and volunteers are reviewed on their individual qualifications for a position. Under no circumstances will Camp Promise discriminate against qualified persons on the basis of race, color, religious creed, retaliation, national origin, ancestry, sexual orientation, gender identity or expression, disability, mental illness, genetics, choice of health insurance, family or marital status, age, veteran status, or any other basis prohibited under applicable law.

This policy applies to all recruitment practices including but not limited to hiring, promotion, demotion, layoff or termination, or professional development and training. Discrimination of any type, including retaliation against an individual filing a charge or making a complaint, is not tolerated.

Americans With Disabilities Act

The Americans with Disabilities Act (ADA) protects disabled individuals from discrimination in employment and other major aspects of everyday life. The ADA defines a “qualified individual with a disability” as an individual with a disability who can, with or without reasonable accommodation, perform the essential functions of the job that such individual holds or desires.

Reasonable accommodation to the known physical or mental limitations of the employee will be provided unless the accommodations impose an undue hardship on the operation of Camp Promise or the individual is incapable of performing the job functions without creating a substantial risk of harm either to himself, herself, or others. Accommodation suitable for individual employees will be determined on a case-by-case basis by Camp Promise in consultation with the individual and perhaps medical experts.

If you have a disability and believe an accommodation is necessary to enable you to perform the essential functions of your job, you should advise management of the disability and suggest the nature of the accommodation you believe is necessary to enable you to perform your job. All information concerning disabilities will be kept confidential and will be distributed on a need-to-know basis. Anyone found to be engaging in any type of unlawful disability discrimination will be subject to disciplinary action, up to and including termination.

If you have any questions regarding this policy, you are encouraged to discuss them with the Camp Directors.

Policy of Respectful Workplace

All Camp Promise staff have a responsibility to treat others with dignity and respect at all times. All staff are expected to exhibit conduct that reflects professionalism and inclusion during camp, at camp functions on or off the campgrounds, and at all other Camp Promise-sponsored and participative events. Staff must exhibit conduct that demonstrates our values and guiding principles, with efforts that encourage:

- Respectful communication and cooperation between all staff members; and
- Teamwork and staff participation, permitting the representation of all staff perspectives.

Camp Policies

Camp counselors and staff are the primary instruments through which the objectives, goals, and philosophy of Camp Promise are transmitted to the camper. All counselors, staff, and general volunteers are expected to be aware of and abide by the following policies:

1. ORIENTATION & STAFF TRAINING: All staff are required to participate in the mandatory pre-camp orientation session during which they will learn about camp, our campers, and our community. Staff will also learn about neuromuscular diseases and receive hands-on training in how to care for campers with neuromuscular diseases. Training includes, but is not limited to lifting and transferring, pushing wheelchairs, and providing personal care such as assisting with feeding, using the bathroom, and getting dressed.
2. CLOSED CAMP: Once camp is in session, everyone is required to remain on site. Visitors are not allowed at camp without prior permission from the Camp Directors. Any staff member who needs to leave camp property during a session must receive specific permission from the Camp Directors.
3. GUESTS: Due to the short duration of our camp sessions and in order to maintain the safety of our camp community, there are limited opportunities for guests and family members to visit while camp is in session. When possible, all visits must be approved by the Camp Directors prior to the first day of camp. All guests and visitors must sign in with the Camp Directors or a member of the leadership team. Camp Promise reserves the right to ask anyone to leave the property at any time.
4. TOBACCO-FREE ENVIRONMENT: Camp Promise camps and facilities are tobacco-free environments. Smoking or chewing of tobacco is not allowed in any camp facility or on any camp property. This includes vapor cigarettes. Staff who smoke have three (3) times during the day when they may smoke: 1) Before campers wake up, 2) During Hangout Hour (if they are not on duty), and 3) At night after campers have gone to sleep. There is a designated smoking area off property, please ask the Camp Directors for the designated smoking area. Staff should promptly relay any knowledge of any incidence of on-site smoking or other tobacco use by guests or staff to a Camp Directors.
5. ALCOHOL/DRUG-FREE ENVIRONMENT: The possession or use of alcohol, illegal, or illicit drugs is not allowed on site or in vehicles and will result in immediate dismissal. This policy also applies to marijuana, even in states where it may be legalized. Staff are not allowed on site if impaired by the after-effects of drugs or alcohol. Any staff supplying minors with alcohol or any illegal drugs, either on or off site, will be immediately dismissed.
6. CODE OF CONDUCT: All staff are required to read, understand, and adhere to the expectations and Discipline Policy outlined in the Participation Agreement within their Offer Packet (see Appendix 1). Camp Promise expects these rules and policies to be followed at all times during the week of camp. Camp Promise reserves the

right to dismiss a staff member if, in the sole discretion of the Camp Directors, the camper is not behaving in a way appropriate for a camper at Camp Promise.

7. ABUSE AND NEGLECT/CAMPER PROTECTION: As a youth- and young adult-serving organization, Camp Promise has a unique opportunity to help protect all campers. We have adopted a comprehensive set of policies and procedures designed to ensure that Camp Promise continues to be safe for all campers and staff. Camp Promise has a zero-tolerance policy for incidents of child abuse. We understand that protecting campers is our most important responsibility, and that our programs serve no positive purpose if we do not ensure their safety. In every case, the report of molestation and abuse, or suspected molestation or abuse, will be treated with absolute priority and Camp Promise will do everything in its power to ensure the successful prosecution of the perpetrator to the fullest extent of the law. As part of our prevention efforts to keep campers safe, all staff are background checked on an annual basis and trained annually to identify and report suspected abuse.
8. SEXUAL HARASSMENT. Sexual harassment is a form of sex discrimination that violates Title VII of the Civil Rights Act of 1964. It is against policy for any staff, male or female, to sexually harass others. Staff who believe they are victims of sexual harassment or have witnessed sexual harassment are to immediately report it to the executive Camp Directors. It is both a violation of federal law and Camp Promise policy to retaliate against someone who has reported possible sexual harassment. Camp Promise will take the necessary steps to protect from retaliation those who in good faith report incidents of potential sexual harassment.
9. CONFIDENTIALITY: In working with our campers, staff will be privy to information that is confidential in nature, including but not limited to that concerning campers and their families, personal and medical information, and medical records. This information must be kept strictly confidential. Confidentiality must be maintained at all times and staff are asked to only share information about campers with other staff on a need-to-know basis and in a private setting (out of earshot of other campers or staff). Don’t forget, our camper’s confidentiality is important to maintain even after camp.
10. COMMUNITY RELATIONS: All staff members represent Camp Promise in their words and actions when at camp, while representing Camp Promise off site (including resource fairs, fundraisers, etc.), while associating (formally and informally) with friends and family who know of their affiliation, and while wearing Camp Promise apparel. Whether you are on or off duty, at camp or off site, your actions, attitude and dress (both good and bad) reflect upon the purpose of Camp Promise. In addition, parents and campers (both current and past) will always see our staff as representatives of Camp Promise, and what you do in the presence of campers away from camp reflects on camp. Therefore, staff are asked to present themselves in ways that are professional, service-focused, family-centered, and respectful at all times. We ask that you refrain from engaging in any activity or behavior that could reflect unfavorably on yourself or on Camp Promise. Staff is

asked specifically to consider how photos and information of themselves may be shared on the Internet.

11. FACILITIES AND VANDALISM: All staff members are responsible for care of the camp's buildings and equipment. Camp Promise does not tolerate marking on walls, cabins, or bunk beds, slashing or carving trees, or other forms of vandalism. All staff members are also expected to assist with cleaning and housekeeping duties as assigned by their UL, Camp Directors or Assistant D
12. RELATIONSHIPS AND DATING: Camp is about the campers and staff are expected to conduct themselves in a way that respects the dignity, personal worth and rights of others, including campers. When on duty, all relationships between staff members will remain strictly platonic. While romantic relationships may occur, they should never become evident to campers or impact the camp program. All relationships should remain professional and any conflicts or issues should be dealt with appropriately and should not impact campers or the camp program. Camper-counselor relationships are absolutely prohibited.
13. FOOD: Complete respect for the kitchen staff shall be maintained. All other staff member should stay out of the kitchen unless otherwise directed by the Head Cook. All staff using the kitchen will be responsible for its cleanliness. Any uneaten food removed from the kitchen should be disposed of properly and dishes/utensils should be returned to the Dining Hall.
14. PERSONAL PROPERTY: Camp Promise is not responsible for any theft, loss, or damage of personal property. To keep track of your belongings, we recommend labeling your items. Please do not use other's personal belongings without explicit permission from the owner.
15. PURCHASING: No purchases or expenditures are to be made in the name of the Camp Promise without proper authorization. Persons making unauthorized purchases will be held responsible for them. Camp Promise and the Jett Foundation will not reimburse for items without prior authorization of the Camp Directors.
16. PHOTOGRAPHY & VIDEOGRAPHY: Neither photographs nor video may not be taken of campers nor staff without written parental consent (or self consent for those over 18 years of age). Any campers for whom Camp Promise has not received consent to photograph, may not be photographed or videotaped. Written consent must also be provided for any image to be distributed or used in brochures, on the web, or in any other sources. At the end of each camp session, a yearbook of photos from the week will be distributed, and only those for whom we have obtained photo releases may be included.
17. SOCIAL MEDIA: We understand that the use of social media is a common method for sharing information and experiences with friends and family. However, Camp Promise must also ensure the confidentiality and dignity of our campers, and the integrity of our organization is preserved in public forums. When posting information about your camp experience and pictures of campers, please ensure that all images and comments are appropriate. Tagging campers and posting camper names is specifically prohibited. We encourage you to Like and follow Camp Promise on Facebook,

Instagram and Twitter. When camp is in session, Camp Promise will post photos daily on our Facebook page but will not tag campers nor post camper names. We welcome campers and their families to tag themselves.

18. EMERGENCY RESPONSE: All employees must familiarize themselves with crisis prevention plans; identify the locations of the on-site fire extinguishers; and learn the proper operating procedures. In case of any emergency, dial 911.
19. GRIEVANCES: Should there be a disagreement over the interpretation of camp policies or a grievance related to one's duties or relationships with fellow staff members, it should be reported to one's supervisor promptly. Should the supervisor be the source of the grievance, the staff member may report the grievance to the supervisor of the supervisor or to the Camp Directors.

Health and Safety

The health and safety of each camper is our primary concern and begins even before the first day of camp. Here are some of Camp Promise's health and safety procedures:

1. Camp Promise staff speak with all campers (or their parents/guardians) prior to camp to answer all questions and make sure we have everything we need in order to make sure the camper is safe and comfortable at camp. The Medical Team also reviews all campers' medical forms and medication lists prior to camp.
2. Camp is staffed 24-hours a day by a qualified Camp Directors and leadership team, as well as by a Medical Team composed of currently-licensed nurses. Sometimes we also have respiratory therapists, doctors, EMTs, physical therapists, and occupational therapists on site.
3. Campers are always supervised. We provide a 1:1 camper-to-counselor ratio such that each camper is assigned his or her own counselor for the week of camp, including in the pool for swimming activities.
4. Our camp radios are an integral component of our safety and security plans. Camp leadership team members, ULs, and logistics and program team members carry walkie talkies at all times.
5. All staff use **universal precautions** when dealing with bodily fluids and providing personal care to campers. Infection control measures such as gloves, antibacterial soap, hand sanitizer, and bleach spray protects both campers and staff from disease-producing microorganisms.
6. The Camp Directors, Medical Team, counselors, and all staff manage the health of all campers by following all parent/physician instructions.
7. The Medical Team is responsible for administering medications, providing first aid and seeking emergency medical treatment in the event of an emergency. The Medical Team is able to evaluate and treat most minor illnesses and injuries, as well as stabilize serious medical conditions. Should it be necessary the Medical Team will also arrange transportation and admittance to a hospital in case of emergency.
8. Campers receive a health screening at check-in where the Medical Team evaluates each camper for illness, injury or communicable diseases, verifies health information and collects all medications.
9. All camper and staff medications remain locked in the nurse's station and are administered by the camp nurse. This includes all prescription medications (such as steroids, antibiotics, birth control pills, asthma medications, insulin, etc.) and all non-prescription medications (such as allergy pills, cold tablets, vitamins, antacids, etc.).
    a. ***A note about medications:** The Camp Promise nurse(s) is/are the only individual(s) allowed to administer medications to campers. Medications should NEVER be kept in cabins and campers should never have access to medications.
    b. Staff who bring medication to camp must turn in their meds to the nurse

for storage prior to camper arrival. While all staff medications must be stored at the nurse's stations for the week, staff will be able to self-administer their meds while at camp.

10. In the unlikely event of a serious injury or illness requiring immediate, specialized medical attention, camper or staff care will be turned over to the local emergency medical service. The use of ground or air ambulance service may be required. Services provided by the Camp Promise Medical Team are offered at no cost. Individuals needing additional medical attention on or off property, for example prescriptions, doctors, or hospital visits, will be billed for services rendered at their expense. All expenses associated with this additional treatment become the responsibility of the camper and/or their parent(s) or guardian(s), preferably handled through their personal health insurance or supplemental accident insurance. The following procedures will be followed if emergency care is necessary:
11. In the event of a medical emergency, a camper or staff member's parent(s) or guardian(s) (if the individual is a minor), or their emergency contact (if the individual is over 18 and does not have a guardian other than themselves) will be notified of any serious illness or injury as soon as possible. In the case of a severe accident, parent(s), guardian(s) and/or emergency contacts will be contacted as soon as possible after administering or securing proper medical care.
    a. In the event that a parent or guardian cannot be reached, a minor's Emergency Contact(s) will be notified. In the event that an individual's Emergency Contact(s) cannot be reached, the Camp Directors and Medical Team will make decisions on their behalf.
12. A staff member will accompany campers requiring medical services off camp property. The staff member must obtain the camper's medical form and copies of their health insurance card from the camp office before leaving camp.

Universal Precautions

The term “Universal Precautions" refers to infection control measures that all healthcare workers and child care providers follow with the goal of protecting themselves and the clients/patients in their care from disease-producing microorganisms. The concept requires workers to treat all blood and various other bodily fluids as if infected with HIV, hepatitis B virus, and other bloodborne pathogens.

At Camp Promise, staff are responsible for providing intimate personal care, plus we engage in many activities where campers explore nature and interact with others, so both minor and major injuries are a possibility (though we do our best to prevent them!). In rare circumstances, contact with blood or other body fluids can be a means of infection transmission. Thus, all Camp Promise staff must understand and use the basic principles and proper precautions to prevent the spread of infection.

The following are the basic principles of universal precautions.

Contact with blood must be avoided. If a camper scrapes a knee or cuts himself, staff should be sure that no other camper touches the blood. In the administration of first aid, there must be a barrier between the person helping the camper and the blood. Examples of barriers include towels, a t-shirt, a bandana, bandages, or whatever is accessible. Gloves should be provided throughout the camp where cleansing may be needed and at every activity area. ***We recommend carrying a pair of gloves in your pocket at all times.***

All body fluids (except sweat) should be considered potentials for infection. Blood is the major risk for transmission for the serious bloodborne infections like HIV and hepatitis B. Direct contact with urine and stool should be avoided, because other pathogens (such as CMV or diarrhea causative agents) can be spread via these fluids. Saliva and spit and nasal drainage are major ways respiratory viruses are spread. Tears are not a major source for infection, and sweat is not considered a risk.

When providing personal care to campers, staff members may be exposed to bodily fluids. To protect themselves and their campers, staff members are required to wear gloves when providing personal care to their camper.

Always wash your hands. Hand washing is the single most effective way to prevent the spread of infection. You can spread certain germs casually by touching another person. You can also catch germs when you touch contaminated individuals, objects or surfaces and then you touch your face (mouth, eyes, and nose).

Different situations where people can pick up infectious germs include:

- When hands are visibly soiled.

- After using the bathroom (includes changing diapers or helping your camper in the bathroom).
- After blowing your nose or after sneezing in your hands (including helping your camper blow their nose).
- Before and after eating, drinking, and handling food (for yourself and your camper).
- After touching raw meat, poultry, or fish.
- After handling garbage.
- Handling pets, animals or animal waste.

All camp staff must wash their hands properly before and after all of these situations in order to reduce disease transmission. “Good” hand washing techniques include using an adequate amount of soap and lathering up (rinsing hands in water only is not as effective), rubbing the hands together to create friction, and rinsing under warm running water. Hands should be washed for a minimum of 15 seconds, and longer if the hands are visibly soiled.

The use of gloves and/or hand sanitizer is not a substitute for hand washing. While staff members should always wear gloves when exposed to bodily fluids or providing personal care, staff should ALSO wash their hands after removing their gloves.

Universal precautions apply to everyone. The term “universal precautions” emphasizes that infection control measures apply to everyone, staff and campers. Many persons can harbor infectious agents and be asymptomatic and unaware. Confidentiality mandates that camp staff may not be aware of an individual camper’s diagnosis. Universal precautions assure that all people are treated equally.

Specific examples of prevention measures are the following.

- **Injury involving blood:** Do not touch the blood. Put on gloves and use a barrier to stop the bleeding and cover the injury.
- **Wet bed or loss of stool or vomit:** Wear gloves—do not touch urine, stool, or vomit with bare hands. Clean up the camper and area as appropriate. If the environment needs cleaning, wear gloves and use a cleaning solution. Put soiled clothes and sheets where others will not touch them. Laundry is available for these emergency situations.
- **Use of restroom:** Staff should wash hands with soap for 30 seconds after use of restroom. When helping a camper use the restroom, staff should wear gloves and then wash their hands with soap for 30 seconds after taking off their gloves.

Camper Supervision

Staff are required to supervise camper groups at all times and it is camp policy that campers are never left alone and unsupervised. We expect our 1:1 Counselors to be with their camper at all times when they are on-duty. Staff are expected to care about their campers, to know where they are, what they are doing, and how they are adjusting to camp life. Individual discipline problems blocking positive group life should be reported and discussed with the Camp Directors.

There may be times when a counselor needs to run back to the cabin and get something, in which case they may leave their camper with another counselor for a **limited period of time.** In such an instance, the counselor must specifically ask another counselor to watch their camper, and is required to tell their camper where they are going, how long they will be, and who will be watching them in their place.

Staff should never be alone with a camper and should always be with another staff member or counselor-camper pair. **This is called the buddy system** and is in place to protect staff members and campers**.** For example, in the case of an emergency, one staff member can stay with the camper while the other can go for help. Or when assisting with a camper's intimate personal care, a third person can provide a third perspective in the case of suspected abuse.

Any medical concerns should be brought immediately to the nurse. Concerns include, but are not limited to:

- Any head injury is an emergency – call the nurse immediately should a head injury occur.
- Any cuts or scrapes of unknown origin
- Any bruise
- Any fall
- If a camper is not eating or drinking
- If a camper seems out of sorts or ill
- Any area of possible infection
- Seizure longer then parent/ guardian communicated length of concern, or any seizure going past four minutes.

Discipline Guidelines

- Staff may NOT, under any circumstances, hit a camper.
- Staff may not use abusive or derogatory language with campers.
- Staff need to ask for help whenever they are unsure of something or need an extra hand caring for campers.
- A staff member who encounters a particularly difficult camper should seek the assistance of another counselor, a Unit Leader, or one of the Directors.

- In all dealings with campers, staff should strive to *respond to* rather than *react to* campers.

Guidelines for Camper-Staff Contact

- On the hand, shoulder, or upper back
- Never against a camper's will (unless in the case of clear and present danger of the camper)
- Never against a camper's discomfort, whether expressed verbally or nonverbally
- Only in the company of other adults
- Never when it would have the effect of over-stimulating the camper
- Never in a place on a camper's body that is normally covered by a bathing suit, unless for a clear medical necessity, and then only with supervision from another adult
- Ask yourself, "Would I do this in front of the camper's parent or caregiver?" If the answer is no, then do not do it.

The following are examples of **appropriate** physical contact with campers:

- Sitting beside children
- Lightly or briefly patting a child on the back or arm.
- Holding hands or interlocking arms (when age appropriate).
- Gently ruffling a child's hair.
- Combing, brushing or braiding of hair.
- Hugs- if requested or initiated by camper.

It is important to note that every camper and his or her physical boundaries are different. If you see a camper withdrawing or pulling away, provide less physical contact and respect the camper's greater need for body space.

The following are examples of **inappropriate** touching or physical contact with a camper:

- Lap-sitting
- Playing rough
- Pulling arms, pinching or hitting
- Placing a hand on the back of a camper's neck to guide
- Forcing a hug on a camper
- Lying down beside a child in their bed
- Back rubs
- Kissing a camper anywhere on their face or body
- Physically guiding campers where you want them to go
- Shoulder rides

Guidelines for Staff

- Hazing of campers by campers or staff is not allowed.
- Campers will not be subjected to 'initiation' rites that are abusive in any manner.
- There will be double coverage of campers by counselors during changing times.

- Younger children should be encouraged to change their own clothes as much as possible.
- Campers will not be alone with a counselor in his or her quarters, or within the bathroom.
- A staff member will under no circumstances share a bed or sleeping bag with a camper.
- Staff will set limits with campers who ‘cling’ or hang on them, both physically and emotionally.
- Staff will not give back rubs unless another adult is present, and then only with clothes on and for comfort purposes.
- Tickling or teasing a camper to the point where that camper is out of control is unacceptable.
- Pillow fights or wrestling matches and the like can become over-stimulating in short order and need to be limited and carefully supervised.
- Romantic lives of staff cannot, under any circumstances, be shared with campers.
- Staff should stay out of cabins other than their own after lights out at night unless on specific camp business.
- Staff working with adolescent campers need to be aware of the tendency for this group to develop crushes.
- Whatever is done with campers should be done in broad daylight, with company.
- Staff should not engage in or promote “locker room talk” amongst campers or staff.

Abuse and Neglect Policy

All staff are required to act in ways that protect the health and safety of all camp participants and to treat them with respect and dignity. Affectionate touch and the warm feelings it brings is an important factor in helping children grow into loving and peaceful adults. However, camp staff need to be sensitive to each person's need for personal space (i.e., not everyone wants to be hugged). Our camp encourages appropriate touch; however, at the same time prohibits inappropriate touch or other means of sexually exploiting children.

All individuals receiving services from Camp Promise shall be free from neglect, emotional abuse, physical abuse, or mistreatment. Any incidence shall be immediately stopped, the circumstances will be investigated and corrective action, where needed, will be taken.

We cannot be too careful in the area of sexual abuse. Even the appearance of wrong or a false allegation can cause irreparable damage to the reputation of the accused staff member and the camp. Therefore, all staff members must be very cautious in order to avoid doing anything that could be interpreted as sexual abuse.

In a camp setting, physical abuse is most likely to happen when a counselor is disciplining a rebellious or unruly camper. Anything done to inflict pain while disciplining a camper is considered child abuse.

Staff are required to IMMEDIATELY report suspected or known cases of abuse or neglect to the Camp Directors. This includes suspicion of abuse occurring before and while at camp. Staff are also required to report any situations where people are not treated with respect and dignity and/or any situations that compromise the health and safety of all camp participants.

In any of these cases, documentation must be provided. All forms for these reports are available in the camp office.

What qualifies as abuse or neglect?

- **Abuse:** The willful infliction by a caregiver of physical pain or injury, or the willful deprivation of services necessary to the physical safety of an individual.
- **Assault:** The act of intentionally causing physical injury or harm.
- **Neglect:** The failure by a caregiver, through action or inaction, to provide an individual with the services necessary to maintain his or her physical and mental health and safety, including incidents of inappropriate or unwanted individual to individual sexual contact.
- **Psychological abuse:** Acts that inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade, demean or otherwise negatively impact the mental health or safety of an individual.

- **Sexual abuse**: Any sexual contact or encouragement of sexual activity between a family member, paid staff or a volunteer and an individual, regardless of consent. The behavior may or may not involve touching. Sexual behavior between a camper and an adult is always considered forced, whether or not the camper has consented.
- **Sexual contact:** Fondling of the breasts, genital area, abdomen, inner thighs or buttocks, masturbation or sexual intercourse.
- **Sexual intercourse**: Vaginal intercourse, anal intercourse, fellatio or cunnilingus between persons regardless of sex. Penetration, however slight, is sufficient to be considered vaginal intercourse, anal intercourse or fellatio and does not require emission of semen. Penetration may be committed by an object manipulated into the genital or anal opening of the individual's body.
- **Verbal abuse**: The use of offensive and/or intimidating language that can provoke or upset an individual.
- **Willful:** Intentional acts or omissions or the reckless disregard for the safety and consequences of one's acts or omissions.

How will you recognize abuse or neglect?

- **Providing personal care**: If you see any bruises or bodily injuries while providing personal care to a camper, such as when assisting with toileting or showering, bring it to the attention of your Unit Leader or Camp Directors. This would be useful in any instances of physical or sexual abuse.
- **Camper comments:** If campers say anything that seems suspicious, bring it to the attention of the Unit Leader or the Camp Directors. Do not ask any leading questions. All comments will be taken seriously by the Camp Directors., however, jumping to conclusions will not help us in helping campers. If something is heard in passing, make a mental note or write it in the camper's care chart for future reference.
- **Staff observation:** If you see ANYONE, including another staff member, abusing a camper in any way, it is your responsibility as a professional member of Camp Promise staff to report it. This report can be made verbally or in writing, but must be brought straight to the attention of the Camp Directors. All reports will be taken seriously.

What kind of abuse should we be aware of?

- **Camper-to-camper:** Beware of camper interactions. Any of the aforementioned abuse types between campers should be brought to the attention of your Unit Leader, or to the Camp Directors.
- **Staff-to-camper:** Any of the abuse witnessed or suspected should be brought immediately to the attention of the Camp Directors.
- **Caretaker-to-camper:** Any signs of abuse that may appear from home, visible when the camper arrives.

Why do we have to report abuse or neglect?

- As caregivers of children and potentially vulnerable adults, we are mandated reporters for our campers. This means that we are legally obligated to report any suspected abuse to the above agencies. Not doing so can put us as individuals and as a camp in danger of neglect ourselves by NOT reporting.

How do we report abuse or neglect?

- In any case of suspected abuse, speak to the Camp Directors immediately. The Camp Promise Directors will take prompt and immediate action, including notifying the appropriate authorities and parents, as well as take appropriate internal action.
- At the first report of probable cause to believe that a child-abuse incident has occurred, the staff person receiving the report will notify the Camp Directors, who will then review the incident with the Jett Foundation Executive Director.
- The camp will make a report in accordance with relevant state or local child abuse reporting requirements and will cooperate to the extent of the law with any legal authority involved. Most states mandate each child-care provider to report information they have learned in their professional role regarding suspected child abuse. In most states, mandated reporters are granted immunity from prosecution.
- In the event that the reported incident(s) involve a staff member, the Executive Director will, without exception, suspend the staff person from camp. The parents or legal guardian of the child(ren)/vulnerable adult(s) involved in the alleged incident will be promptly notified in accordance with the directions of the relevant state or local agency.
- Reinstatement of the employed staff person will occur only after all allegations have been cleared to the satisfaction of the director. All camp staff and volunteers must be sensitive to the need for confidentiality in the handling of this information and therefore, should only discuss the incident with the Camp Directors or Executive Director.

Record Keeping and Forms

We keep detailed, up-to-date, and accurate documentation all the time. This includes Camper Care Charts, Accident/Incident Reports, and other written reports. Staff must all work together to help ensure that all paperwork is up to date and accurate.

Camper Care Chart

The Camper Care Charts help us document camper health throughout the week. Charts will be stored in a binder in each cabin and all counselors must complete their camper's care chart at the end of each day. Unit Leaders will collect the binder each morning and turn it into the camp nurse at breakfast. All camper care charts will be reviewed daily by camp nurses and may be reviewed at the end of the week by parents/guardians.

See Appendix 2 for a copy of the Camper Care Chart.

When completing a Camper Care Chart, information should be as detailed as possible:

- Tooth brushing should happen twice a day, every day.
- Showers can be taken every other day (campers who wear diapers, or who have an accident may need showers more often).
- Document dates and times for all bowel movements. If your camper is ambulatory or doesn't need assistance in the bathroom, you may need to ask them for this information. Concerns should be addressed in the Notes section (e.g., diarrhea more than once should be brought to the nurse, as well as any blood in the stool).
- Fluid intake and output can be in occurrences (e.g., drank six glasses of water, urinated three times, three diapers changed, catheter changed once, etc.).
- Sunscreen should be applied three times per day, and bug spray should be applied as needed.
- Document camper's food intake, noting if they are picky eaters or not eating enough.
- Document all stretches and non-medication treatments such as breathing treatments, prescription mouth-wash, powders, etc.
- Document any homesickness.
- Skin breakdown is a serious concern and counselors are required to document any skin breakdown or pressure sores the camper has upon arrival, or that develop during camp. Skin redness should also be documented here, as it is the precursor to a pressure sore.
- General mood and participation should be documented, especially bad moods and low engagement in activities.
- Document whether a camper's equipment is in working order each day, and specify if anything is broken upon arrival, or breaks during camp (e.g., glasses, braces, wheelchair, scooter, bi-pap, orthotics, etc.)
- Notes section: Include if an accident/incident report form was filled out that day.

- The second page is for counselors to describe, in 3-4 sentences, how each day went, what the camper did, and any concerns in more detail.

Accident/Incident Report

All accidents and incidents must be documented on the Camp Promise Accident/Incident Report form. Blank Accident/Incident report forms can be obtained from your Unit Leader or the camp office. Issues or incidents that appear small or insignificant can, in fact, become larger quickly at camp. To protect staff members and campers, Camp Promise encourages staff to "document, document, document" and to follow the guideline of "when in doubt, write it out."

See Appendix 3 for a copy of the Accident/Incident Report.

This form is to be completed for "anything worse than a Band-Aid." Use the following 8Bs as guidance:

1. Blood
2. Barf
3. Bones injuries
4. Bites (human, animal, or severe/infected insect bites)
5. Burns
6. Bruises
7. Bowels (atypical or accidents)
8. Behavior
    a. Negative camper or staff behavior
    b. Suspected theft or possible loss
    c. Suspicion of possible child abuse
    d. Invasion of camp property by outsiders
    e. Damage to camp property or equipment
    f. Accident or damage to camp vehicles, golf carts, bicycles, etc.
    g. Any incident where fortunately no injury occurred, but there exists the potential for future problems (i.e., Pontoon boat hitting the dock, gas leak fire with a Coleman stove, medication error, belted wheelchair on the dock/at the pool, etc.).

Be as thorough as possible when filling out all Accident/Incident Reports:

- Complete the form with just the facts, do not include interpretations or judgments.
- Reports must be received the SAME DAY as the incident.
- All reports MUST be signed.
- Multiple individuals may be required to complete a single report (all witnesses and responding staff, camp nurse, etc.).
- Include all resolutions of the incident.
- Include any follow up with the camp nurse or parents/guardians.

Emergency and Safety Procedures

Every precaution is taken to ensure a healthy and safe camp experience for all campers and staff. However, accidents and medical problems do occur. No two emergencies are the same, but all staff must familiarize themselves with the following emergency prevention and response plans.

While the various steps and suggestions outlined in these procedures represent the camp's guidelines, staff members should use their own good judgment until they are able to contact assistance. The goal is to always save a life. The safety and well-being of the campers and staff ALWAYS comes first and staff members should always remove persons from a life-threatening situation.

Camp Radios

Camp radios are an integral component of safety and security plans. Camp Directors, Unit Leaders, Medical Team, and Program and Logistics Team members will carry a radio at all times. In case of emergency or in the need for help, find one of these team members and ask to borrow their radio.

Camp Promise staff are asked to follow the following radio usage rules:

1. Campers should never have, hold, or use a radio. These are expensive pieces of safety equipment that are not to be used as toys.
2. When using the radio, first state your name and then the name of the person you are trying to reach. For example:
    a. "Sam to Sally."
    b. "This is Sally."
    c. "Sally, what is your location?"
3. The volume on radios are set to high. This means that everyone in the vicinity of radio-carrying staff members will hear your conversation. Remember to respect camper's privacy and prevent the spread of panic when communicating via radio.
4. Urgency vs. Emergency: It is important to accurately convey your level of need over the radio so as not to incite panic.
    a. If you need **urgent** help but your situation is not an emergency, please ask for "walking feet." For example, when a camper needs a Band-Aid, if a camper's Bi-pap or feeding tube is beeping, or running out of gloves while your camper is on the toilet. Sample call:
        i. "Sam to Nurse Sarah"
        ii. "This is Sarah"
        iii. "Can I please have walking feet to the soccer field, camper AB's vent is beeping?"
    b. If you need **emergency** help, please ask for "running feet." For example, if a camper falls out of his or her wheelchair, is choking, or cannot breathe. Sample call:

i. “Sam to Nurse Sarah”
ii. “This is Sarah”
iii. “Can we get running feet to the men’s locker room? Camper PG has fallen out of his shower chair. Counselor Ron is with him. He is bleeding a little from his left foot, but is laughing.”

Dos:

- Stay off the radio unless absolutely necessary.
- Listen before you begin your transmission. Always wait a second before you speak after keying the push-to-talk button.
- Be brief and to the point.
- Convey the level of urgency/emergency without causing alarm.
- Acknowledge the receipt of all messages directed to you regardless of content.

Don’ts:

- Wait until a previous conversation is completed before initiating a new conversation.
- Move longer conversations to a second channel so as not to take up our primary channel, which is our emergency line.
- **Do not use camper names.** We us an open radio channel and must protect the privacy of our campers. When requesting help or input for a situation with a specific camper, use initials instead of their full name.
- Do not talk too much. Only speak when absolutely necessary. Safety information must take priority.
- No joking or chatting.
- Do not interrupt conversations with a new call.
- Do not shout or swear.

When Something Goes Wrong

1. Use a radio or send someone for help.

    a. Walk calmly, but with purpose. Running through camp may spread panic and worry.
    b. Know the camper's first and last name (only use camper's initial if radioing for help).
    c. Be able to share the individual's specific location and identify who they are with.
    d. Identify the level of emergency and what supplies might be needed.
2. Stay calm; panic is contagious. All staff should prevent panic by distracting campers, and remaining calm, assuring, and under control.
3. During an emergency, counselors and staff are to remain with their campers.
4. Distract other campers away from the scene. If other campers can't leave the scene, you may need to build a human wall around the person being treated so as to provide them with privacy and protect other campers in the area.
5. Unit Leaders are responsible for taking attendance during emergency situations, knowing which of their campers and staff are unaccounted for, and reporting this to the administrative staff.
6. After the incident, submit an Accident/Incident report form documenting the incident. This may need to be completed by multiple individuals (counselor(s), nurse, etc.).

Medical Emergencies

In the event of a serious accident, injury or illness, the following procedures will be followed:

1. Save a Life. Remove persons from a life-threatening situation immediately.
2. In an extreme emergency, administer appropriate first-aid.
3. If the victim can be moved, transport the individual to the nurse's station.
4. If the individual cannot be moved, immediately use a radio to call or send someone for the nurse. If the nurse does not answer, call the Camp Directors. If the Camp Directors are not available, call the main office or administrative staff.
5. The Nurse will assess the individual's injuries and determine whether and what emergency service(s) are needed. The decision to contact outside assistance, such as Poison Control, Police, Fire, or Ambulance, will be made by the nurse in consultation with the Camp Directors. If the individual requires immediate, specialized medical attention, their care will be turned over to the local emergency medical service. This will be coordinated by the camp nurse and Camp Directors.
6. Should the individual need transportation off-site to a local clinic or hospital, the Camp Directors will determine who should accompany them. Campers requiring medical services off camp property will be accompanied by their counselor or a staff member. The accompanying staff member must bring with them:
    a. The individual's medical form and copies of their health insurance card from the camp office.
    b. A cell phone and charger so as to remain in contact with camp.
7. The Camp Directors or his/her designee will notify the camper or staff member's parent(s) or guardian(s) (if the individual is a minor), or their emergency contact (if the individual is over 18 and does not have a guardian other than his/herself) as soon as possible. In the case of a severe accident, parent(s), guardian(s) and/or emergency contacts will be contacted as soon as possible after administering or securing proper medical care.
    a. In the event that a parent or guardian cannot be reached, a minor's Emergency Contact(s) will be notified. In the event that an individual's Emergency Contact(s) cannot be reached, the Camp Directors and Medical Team will make decisions on their behalf.
8. The Camp Nurse is to submit, <u>within eight hours of the incident</u>, an accident/incident report form to the Camp Directors.
9. If the incident draws media attention, **ALL** inquiries are to be directed to the Camp Directors.

Fire, Natural Disasters, Missing Campers, and Intruders

Appendix 4 contains site-specific emergency response plans for crises such as fires, hurricanes, tornados, missing campers and intruders. All staff must familiarize themselves with these emergency procedures (see Appendix 4). All staff are required to identify the locations of the on-site fire extinguishers and learn the proper operating procedures.

In case of emergency, dial 911.

Staff Orientation and guide to check-in

Staff Orientation is an exciting day at camp when we get to meet new faces and see old friends. Our Unit Leaders and Leadership Team are here to welcome you, so if you have any questions, don't hesitate to ask. Please review the procedures outlined below so we can work together in making it a smooth and exciting experience for all.

1. Your Welcome Packet, sent via email, will contain most details you will need for Orientation, including the camp's address, when to arrive, and where to meet on site.
2. Orientation typically begins at 10:00 a.m. (with specific time and location announced prior to camp), and we ask that you arrive on time. Please do not be late. This is the first day of your job and first impressions matter.
3. Upon arrival, you will be met by a staff member who will direct you to your first check-in station. Please be sure to follow their traffic and parking instructions as we have many cars coming and going which can quickly lead to traffic jams on our small, narrow camp roads.
4. If you are getting dropped off, please have your ride wait, and remain in the car with your belongings, until a negative Covid test result is received.

Staff members will be readily available to assist the volunteer through the check-in process, if needed.

This year due to Covid 19 precautions, the volunteer check-in will be a "drive thru" process, where volunteers will remain inside their vehicles throughout the duration of check-in. To our past volunteers, this process may look different vs. what you are used to, or may seem tedious. But in order to provide the highest level of safety to our campers, volunteers and staff, we have put this process in place as an extra level of precaution. We appreciate your understanding and are happy to discuss this further if you would like to. Please feel free to reach out to Camp Promise Leadership at any time. Info@campromise.org

Station 1: Meet the Medical Team!

- Here the Covid 19 Rapid antigen test will then be administered while you remain inside the vehicle.While awaiting results of the test, (about 15 mins) the volunteer is asked to stay inside of their vehicles.When results are ready, a staff member will let you know!
- If a volunteer tests positive, they will be asked to return home.

Station 2: Once a negative test result is received

Complete a quick health screen, and turn in any medications to our Medical Team. You will be provided with a brown paper bag in which to put them.

Station 3: Meet our Program & Logistics Staff!

Pick up a copy of the week's activity schedule, ,and grab a piece or 2 of Camp Promise swag!! Give us your name, put on a nametag, complete a check-in form, ensure all your paperwork is set and hand in any missing paperwork if necessary, and confirm your contact information for our yearbook, and learn about the fun activities we have planned for the week.

5. Once everyone has checked in, we will begin our Orientation program. The day will be packed with a lot of information, but we'll keep you fueled and energized with snacks, breaks, lunch, and dinner. A general outline can be found below:
    a. Introductions and Ice-breakers
    b. Camp Policies and Procedures
    c. Our Campers Diagnoses
    d. Team Meetings
        i. Counselors divide into cabins and learn more about their campers and specific cabin needs.
        ii. Station training for counselors: Dressing, toileting, feeding, showering/bathing, night care, lifts and transfers, pool transfers,etc.
    e. Program and Logistics team meetings
    f. Camp Programming
    g. Meet The Nurse
    h. Emergency and Safety Procedures
    i. Camp Tour

6. The evening will be spent unpacking, decorating cabins, getting to know your teammates for the week, and getting ready for camper arrival the next morning.

Camper Check-in

Camper check-in day is also an exciting day at camp. We rely on our counselors to keep everything flowing smoothly for campers and their families, so please review the procedures outlined below to make it an efficient and exciting experience for all.

1. Prior to camper arrival, staff will spend the morning decorating camp and setting up for camper check-in.
2. Upon arrival, campers will be met by a staff member who will direct them to their first check-in station. The counselor will escort the camper through the check-in process from outside of the camper's vehicle, once a negative Covid test result is received.

Station 1: Meet the Medical Team!

Here your camper will have the Covid 19 Rapid antigen test administered while the camper is still inside the vehicle. While awaiting results of the test, (about 15 mins) the camper and parent are asked to stay inside of their vehicles.When results are ready, a staff member will let them know!

If a camper tests positive, they will be asked to return home, but will be eligible to return to camp later in the week, if symptom free, and a negative PCR test is obtained.

Station 2: Complete health screen & turn in medications

Once a negative test result is received**,** the camper will complete a quick health screen, turn in medications, review dosing instructions, and discuss any special medical concerns or needs with the Medical Team.

Station 3: Meet our Program & Logistics Staff!

Pick up a copy of the week's activity schedule, sign the Camper Participation Agreement, and grab a piece or 2 of Camp Promise swag!! This is where caregivers and families will learn how they can stay in touch throughout the week.

Station 4: Chat with your camper's family!!

NOTE: Bellhops will remove your campers belongings from the car while you all chat!

This will be a brief time (15 mins) where parents, and caregivers, while remaining in their vehicles, can share any special instructions or routines with counselors, including how campers like to be lifted and transferred and any stretches or treatments campers do. *Please keep in mind- the counselor will have reviewed the campers application prior to their arrival.* We can also do our best to arrange a pre-meeting over phone/video before arrival day if parents and caregivers feel as though a more in depth conversation will be needed.

Station 5: Say goodbye!

This will be where your camper will say goodbye for the week, as this will be the conclusion of check-in!

- Once checked-in, counselors will show campers to their cabin where campers can unpack, set up their bed, and meet other campers in the cabin.
- After campers are unpacked, campers will then proceed with their counselor to lunch or arts and crafts. Lunch will be provided to campers on check-in day, usually at 12:00pm or 12:30pm.
- A camper's first job at camp is to make a nametag, so head on over to Arts and Crafts, and let's get the camp fun started!!

A Day In The Life At Camp

At all of our camps, our days are filled with traditional camp activities, like swimming, fishing, boating, arts and crafts, nature, science, sports and wheelchair soccer, pranks, etc. Each session also has a Prom dance at the end of the week. We also like to mix things up and provide unique and creative activities. While our programming is ever-evolving, in the past we've done wheelchair accessible hot air ballooning, adaptive bicycling, live-band karaoke, and more.

Sometimes cabins will hang out and do activities together, and at other times we'll do things all together as a group. For example, camp-wide activities have included scavenger hunts, music trivia, Jeopardy, dueling pianos, and guest entertainers such as improv groups, rock bands, swing dancing troupes, and more. In general, we have a flexible schedule that allows campers to choose what activities they wish to engage in, and there's plenty of time for just hanging out with friends and cabin mates.

We also have a Transitions Program for our 18+ campers that takes place at our Camp Promise Arizona & the Camp Promise Ohio Retreats. This programming promotes independence and personal decision-making. In the past, this has included sessions on self-defense tailored to our campers' needs and abilities, adaptive technology, dating and relationships, attending college, applying for jobs, and resume writing.

Sample Schedule

7:30am	Wake up, get dressed and ready for the day.
8:30am	Breakfast
9:15am	Flag raising
9:30am-12:15pm	Activity Block 1 (e.g., arts & crafts, music, science)
12:30pm	Lunch
1:30pm	Hangout Hour
2:30pm	Camp-wide activity (e.g., Capture the Flag, trivia, wheelchair soccer)
3:30pm	Swimming and free choice
6:00pm	Dinner
7:00pm	Camp-wide night activity (e.g., Campfire, Casino Night)
9-11:00pm	Cabin-based curfews and hangout time

We think of our camp schedule as a buffet of options for campers. While campers are required to be with their counselor at all times, campers are not required to attend all events as scheduled. Our schedule provides flexibility and there are often multiple activity choices for campers to choose from.

Swimming At Camp

In order to keep all campers and staff safe during the week, the following swimming policies have been established:

1. State law and camp policy require the presence of a certified lifeguard for all swimming and boating activities.
2. It is also Camp Promise policy that there is a 1:1 camper-to-counselor ratio within the pool at all times. All counselors must also stay within an arm's reach of their assigned camper at all times while in the pool.
3. Any person showing evidence of any communicable skin disease, sore or inflamed eyes, cold, nasal or ear discharges, or any other communicable disease may not swim in the pool.
4. Any person with excessive sunburn, open blisters, cuts, or bandages may not swim in the pool.
5. Do not enter the water if you are experiencing or recovering from diarrhea or have had any signs or symptoms of a gastrointestinal (stomach) disease in the past 14 days.
6. All persons in diapers must wear plastic pants with snug fitting elastic waist and leg bands.
7. Conduct that endangers the safety and comfort of others shall be prohibited.
8. Any additional aquatic facility rules will apply on a facility-to-facility basis.
9. Participation in all aquatic activities is at discretion of camp lifeguards and other aquatic facility lifeguards and staff.

General Camp Info

From the moment they arrive at camp , staff members are responsible for the safety and well being of campers. The information below should be considered daily.

Mail

Some of us love to receive mail. Every staff member and camper receives a mailbox at camp that is used for intra- and inter-camp mail. Parents, caregivers, family and friends may leave pre-written mail with the camp staff during check-in to be delivered to campers during the week. Or, they may send letters using traditional mail. NOTE: We do not forward mail after camp. See below for the mailing addresses below for our three camps:

Camp Promise-East (PA):
Volunteer Name, Camp Promise
c/o Arrowhead Bible Camp -122 Arrowhead Cottage Rd, #7703,
Brackney, PA 18812

Camp Promise-Rockies (CO):
Volunteer Name, Camp Promise
c/o Rocky Mountain Village
2644 Alvarado Road
Georgetown, Colorado 80444

Camp Promise-West (WA):
Volunteer Name, Camp Promise
c/o Camp Korey
24880 Brotherhood Rd, Mount Vernon, WA 98274

Camp Promise-Retreat (AZ):
Volunteer Name, Camp Promise
c/o Whispering Hope Ranch
2273 E Colcord Rd
Payson, AZ 85541

Camp Promise-Retreat (OH):
Volunteer Name, Camp Promise
c/o Akron Rotary Club
4460 Rex Lake Dr
Akron, OH 44319

Meals

Our goal is to provide high quality food in a well-balanced menu. The kitchen staff provides three meals a day plus snacks, and is well-versed in the needs of modified diets, including consistency changes, vegetarian diets, gluten-free diets, dairy-free diets and food allergies. Individuals with special dietary requests should include this information on their application and in their interview. Please remind us of any dietary needs upon arrival at camp. In some cases, campers and staff may need to bring supplemental food items to satisfy special needs.

Camp Name Tags

We require that all campers and volunteers wear name tags for the duration of camp. Name Tags help keep everyone safe, allow the nurses to correctly identify campers for treatment and medication passes, and helps confirm who belong and camp and who does not. Name Tags should be worn at all times, except for the in the shower, at the pool, and when sleeping.

Camper's Belongings

Counselors are responsible for keeping track of their campers' items and sending them home with everything they brought to camp—in the same condition, or better, than when it arrived. Counselors are responsible for covering the cost (i.e., postage or delivery) of returning any item their camper leaves behind at the conclusion of camp. Please pay attention when unpacking your camper's luggage so you are aware of what they packed and so that they can use what they brought with them. Don't forget to keep track of dirty clothes, the goal is for no items to be left behind. Keeping cabins clean and organized throughout the week will help greatly!

Lost and Found

Lost and found items will be collected throughout the week and stored in a central location. At the end of each week, all remaining Lost and Found items will be displayed during camper pick-up. Staff, campers, parents, and caregivers are asked to double-check the cabins, activity areas, and the Lost and Found table before departing. Any identifiable camper items left behind at the conclusion of camp will be sent or delivered to the camper and the costs covered by their counselor. Any Lost and Found items that lack identification will be donated after camp. Camp Promise is not responsible for lost or stolen items.

Camp Nurse

A registered nurse is on duty 24/7 at camp and staff members have access to his/her services as needed. The cost of prescriptions, doctors, or hospital visits must be covered under one's personal insurance. Unless it is an emergency, staff should see to their own medical needs with the nurse at an appropriate time that will not affect campers' care and/or supervision.

Staff Medications

Staff meds should be given to the nurse for storage prior to camper arrival. Medications should NEVER be kept in cabins and campers should never have access to medications. While all staff medications must be stored at the nurse's stations for the week, staff will be able to self-administer their meds while at camp.

Laundry

Camp Promise does not provide laundry service during camp. Laundry will be done for emergency laundry needs only. Make sure to pack enough clothes for the entire week of camp, including the theme days and special events planned. We recommend bringing a laundry bag or plastic bag to camp to use for dirty clothes.

Tips and Gratuities

We expect our staff to treat all campers equally. Therefore, staff members are asked not to accept any tips or gratuities from the parents or relatives of campers. Staff members may encourage donations to Camp Promise in lieu of personal gifts.

Electronic Devices and Cell Phones

Camp Promise discourages the use of electronic devices while at camp (with the exception of medical equipment). Except for emergencies, your cell phone should not be used while you are on-duty or visible to campers (with the exception of using it as a camera or alarm). If you are talking or texting or surfing the Internet, you are not supervising campers and campers will perceive your disengagement. Staff cell phone use during on-duty hours or in the presence of campers is restricted to taking photos and setting alarms. Please keep your phone on airplane mode while on duty. All personal phone calls, texts, emailing, and social media use must be made during off-duty hours AND not in the presence of campers.

Cabins

Campers are divided into cabins based on age and gender. This means that male campers bunk with male campers, and female campers bunk with female campers. Our 1:1 Counselors typically, but not always, sleep in the cabins with their campers (if there is no room for all 1:1 Counselors to sleep in the same cabin as their campers, counselors will rotate sleeping in the cabins with their camper. Please see the section on Cabin Duty for more information). Our female campers are always assigned 1:1 with a female counselor, so our female camper cabins only have female counselors. For male camper cabins, some have co-ed counselors while others may have male-only staff. Please be sure to include your cabin preferences on your application and during your interview.

Cabin assignments vary each year based on camper enrollment and space availability. All cabins are color coded and typically divided in the following ways:

- Green: Youngest male campers
- Red: Older adolescent campers (Teens)
- Orange: Young adolescent male campers
- Blue: Older adolescent male campers
- Black: Oldest male campers
- Purple: Female campers
- Pink: Leadership staff; Program, Logistics, and Medical Teams

Cabins differ slightly across our five sites, but most cabins have central heat and air or are temperature controlled. All cabins also have outlets for charging wheelchairs and any medical equipment needed at night. And, all cabins have accessible bathrooms with roll-in showers.

Weather

Camp operates rain or shine. You should pack and be prepared for any weather. In the event of severe weather, we will resume activity in shelters and/or buildings. Please pack layers and sunscreen as we are outside the majority of the day.

Transportation

Camp Promise does not provide transportation to and/or from camp, but we can work with you to explore your possibilities for arranging transportation. Staff carpools are often self-coordinated prior to camp. At no time are campers to be transported in private staff vehicles; in the event of a health emergency, 911 will be called and used for transportation.

Sunscreen and Bug Spray

We will be outside the majority of the day and recommend staff wear sunscreen daily. Due to the concern with Lyme Disease and deer ticks, we also encourage you to pack bug spray.

Camper and Staff Curfews

We are firm believers that sleep is medicine and so important at camp to help things run smoothly. Kids need more than just adults to watch them and our campers need even more staff energy and effort. Therefore, Camp Promise operates a curfew policy for both campers and staff. These guidelines are intended to allow adequate rest after the day's events and enough sleep to keep energy levels up to ensure a quality experience and care for all participants.

Each cabin has its own camper curfew and staff members are asked to enforce it. Campers should be **in bed** by their curfew, not just in their cabin.

All staff need to be in their cabins by the designated **Staff Curfew** time. After their camper's curfew, counselors who are not assigned to cabin duty are permitted to hang out and take care of personal matters.

Camper curfews and staff curfews are set by the Camp Directors and posted on the camp schedule.

Wi-Fi and Internet

Wi-Fi may be available depending on the facility. Typically, some parts of camp will have Wi-Fi, however due to our large campuses and remote locations, it may not extend to every area of camp. Staff may use Wi-Fi on their breaks and after their campers are in bed, however, use of Wi-Fi during the day and in the presence of campers is not allowed. Given that these are shared networks, please do not download or stream TV

shows, movies, or other large files in order to preserve our limited bandwidth.

Language

Staff must use appropriate language at all times. As a role model, you must avoid swearing, telling inappropriate stories, and using language that is demeaning or crude. Locker room talk is not allowed. If such language is observed being used by campers, it is your responsibility to point out that such ways of speaking are not appropriate at camp. Staff should refrain from discussing alcohol or drugs with or near campers.

Pranks

Pranks are a popular tradition at Camp Promise and add a dimension of fun and creativity. All pranks must be pre-approved by the Chief Prank Approver. Each component of a prank requires advance approval and once approval is received, various parts of the prank may not be amended or completed out of order. Pranks that physically or emotionally hurt others, or that destroy others' property and possessions are prohibited.

Golf Carts

Golf cart use is reserved for the Leadership, Medical, Logistics and Program teams only. All golf cart operators must have a valid driver's license on file with Camp Promise. At no time will campers be permitted to ride in golf carts.

Bicycles

Leadership, Medical, Program, and Logistics teams may bring a bicycle to camp to help them get places quickly on some of our large campuses. Counselors and Unit Leaders are not permitted to bring bikes to camp as they are required to stay with their campers at all times. Please note that biking on dirt roads can be dangerous and bikes should only be ridden on the camp approved paths. Safety helmets must be worn. Camp Promise is not responsible for any lost, stolen, or damaged bikes.

Service Animals

There may be some campers who bring their service dogs with them to camp. Remember, they are here to work and will likely go everywhere with their owner. Please ask before you pet them, and encourage other campers to do so, too. If you are not comfortable being paired with a camper with a service dog, please let the Camp Directors know in advance of camp.

Parking

Vehicles are to be parked in designated areas only. Use of personal vehicles during the camp is restricted. If you need to access your car during the week of camp, please speak with the Camp Directors.

Dress Code

Good judgment, appropriate modesty, the needs of our campers, and the type of work we do should dictate what you wear. Remember, you will be bending and lifting a lot during the week of camp. Shirts and shoes are to be worn at all times:

a. **Clothing** may not advertise 1) beer, alcohol, or drugs, 2) sex, or 3) racial, ethnic or other harassment. All slogans must be in good taste.
b. **Shoes** are to be worn at all times. Closed-toed shoes are mandatory (due to the risk of getting one's toes run over by a wheelchair). Due to the safety of our campers and volunteers, flip-flops are NOT allowed at any time, but sandals that have a heel strap may be worn near the pool and when assisting campers in the shower.
c. **Swimsuits:** Camp Promise has a one-piece bathing suit policy. Males are asked to wear swim trunks (no shorts, cut-off pants, or Speedos) and females are asked to wear one-piece suits (no bikinis).

Self-Care

Staff are expected to use good judgment and practice good health habits such as getting enough sleep, eating well, following infection control procedures, and utilizing their breaks for self-care purposes. Remember, happiness is contagious...a happy staff member is a happy camper.

Cabin Duty

Counselors are expected to share the responsibility of Cabin Duty during the week. On a rotating basis, as assigned by Unit Leaders, counselors will have Cabin Duty. There are two (2) times during which staff are on Cabin Duty:

1. Hangout Hour
2. Nighttime

Unit Leaders will work with counselors to create fair cabin duty schedules at the beginning of the week. To learn more about your responsibilities of cabin duty, please see below.

Hangout Hour

On most afternoons there is a one-hour block called Hangout Hour after lunch. During this time, campers are expected to be in their cabin space– some may wish to nap while others may prefer to hangout. Counselors on Cabin Duty during Hangout Hour are responsible for supervising and engaging with campers during this time, including:

1. General supervision of all campers
2. Toileting any campers that may need it
3. The provision of activities during the Rest Hour time, including:
    a. Playing games or cards
    b. Reading to campers
    c. Having an active discussion

All other counselors are off duty during this hour off, but must return before the end of Hangout Hour. Counselors not on Hangout Hour duty are not free until the following are done for their campers:

1. Given the opportunity to go to the bathroom/diaper changed
2. Campers are in the area in which they are choosing to spend Hangout Hour (e.g. cabin, lounge, resting in their bed)
3. Counselors on Hangout Hour are notified of any concerns re: individual campers.

Night Duty

Many campers will need care through the night. In the event that all 1:1 Counselors sleep in the same cabin as their camper, they will be responsible for providing their camper's care. Should a counselor have a particularly long night with very little sleep due to their camper's needs, please let your Unit Leader know. Your Unit Leader will then assign a floater to your camper for the morning and you will have the morning off. You should get your own campers ready for the day as usual, but will then be off until lunch. Please use this time to catch up on your sleep!

In some cases, depending on the cabin layout, 1:1 Counselors will sleep in a different room from their camper. In this case, Unit Leaders will assign counselors, on a rotating basis, to be on Night Duty. Depending on the cabin needs, anywhere from 2-4 staff may be assigned to Night Duty. This responsibility begins at the start of your cabin's curfew, or when all campers are in bed. All counselors not sleeping in the cabin with their camper are still responsible for getting their camper into bed for the night, and should then notify the staff on Night Duty of any specific concerns or instructions for their camper. Counselors on Cabin Duty at night are expected to stay within hearing distance of their cabin (either inside or right outside) in order to assist campers who may call out in need. During the night, Cabin Duty counselors are responsible for:

1. Turning campers during the night
2. Anyone who may need to be toileted

The morning following Night Duty, any staff that were on Night Duty should get their own campers ready for the day as usual, but will then be off until lunch. Please make sure to use this time to catch up on your sleep!

Breaks

Breaks are an important part of your self-care. All staff will be provided with breaks during the week of camp and are expected to use them. Your supervisor is responsible for managing and scheduling these breaks (e.g., Unit Leaders for 1:1 Counselors and Float Counselors, Head of Programming for Program Team members, Head of Logistics for Logistics Team members, etc.). Supervisors are also responsible for ensuring there

is equality in the number and length of breaks staff take. Please communicate your break needs with your supervisor.

Special Note About Counselor Breaks
1:1 camper supervision is required at all times. When a counselor takes a break, another 1:1 Counselor, Float Counselor, or staff member must be assigned to supervise their camper for the duration of that break. Other than Hangout Hour Duty, Night Duty, we must maintain a 1:1 Camper-to-counselor ratio at all times.

Unit Leaders will coordinate breaks for both 1:1 Counselors and Float Counselors. If a Float Counselor is not available to provide coverage, the Unit Leader can speak with the Assistant Director, Head of Programming, or Head of Logistics to see what other staff is available to provide coverage.

When taking a break, don't forget to:

1. Communicate your break with your supervisor.
2. Notify your camper how long you will be gone.
3. Notify your camper who will be watching them in your absence.
4. Let your supervisor know when you are back from your break.

What To Do On Your Break
To get the most "break" out of your break, we recommend using it to rejuvenate yourself. Showering, napping, and/or checking in with friends and family outside of camp are wonderful things to do during a break. Due to our closed campus, you may not leave camp during your breaks.

Keep in mind that not everyone will know you are off-duty when taking your break. To avoid the appearance of "inattentive staff," we ask that you not hang out with counselors who are on-duty as they need to be paying attention to their campers, not you. During a break, you will be considered off-duty only if you are not around campers. Therefore, should you chose to hangout with campers during your break, you will be considered "on-duty" and may not use your phone or other electronic devices to talk, text, email, etc.

The Last Day Of Camp

Camper Pick-Up

The last day of camp is always bittersweet with lots of hugs and “see you soons.”

The general process for camper check-out is provided below:

- The day starts with breakfast as regular. Afterwards, counselors must move their camper’s belongings, as well as their own personal items, to the designated location.
- Parents and caregivers are typically asked to arrive at 10:00 am on the last day of camp. If a camper will be picked up earlier, the counselor will be notified in advance so they can get their camper ready in time.
- All campers must stop by the following stations before departing, while parents/caregivers will stay inside of their vehicles.

  Station 1: Camp Nurse—Pick up remaining medications or empty bottles.

  Station 2: Lost and Found—Please check the lost and found table for any items that may have been misplaced during the week. Any unclaimed lost and found items that lack camper identification will be donated after camp.
- Counselors and bellhops will assist with loading luggage into camper vehicles.
- Before departing, counselors are responsible for making sure their camper checks out with their Unit Leader and the Camp Directors.
  a. ***Please note,** our staff cannot accept tips. If campers or their families wish to show appreciation for the care and service our staff provided, please contribute to Camp Promise online or by seeing the Camp Director at checkout.

Camp Clean Up

We are responsible for leaving the facility as clean or cleaner than we found it on the first day of Volunteer Orientation. To make this an efficient and quick process, the following procedures have been put in place:

1. While counselors and Unit Leaders are checking out campers, Program and Logistics team members will both assist with camper check-out as well as begin packing up supplies, inventorying left over materials, and packing the truck/trailer.
2. Each cabin will be responsible for cleaning their bunk, plus an assigned area of camp. As soon as a counselor’s camper has departed, they are expected to begin cleaning their cabin and assigned area. Once a cabin has cleaned their bunk and their assigned area, they are to join the Program and Logistics team members in packing the truck/trailer.
3. When all of the cabins and camp areas have been cleaned, a walkthrough inspection will be conducted by a member of the facility’s

team.

4. Upon final approval, all Camp Promise staff will meet for a final, mandatory meeting and debrief session. During this time staff will be asked to complete camper review forms as well as an anonymous camp evaluation form. Staff will not be dismissed early, as everyone is required to attend the final staff meeting.

Pending a clean camp, staff will be dismissed by 3:00pm

What To Pack

Please see the Packing List included in your Welcome Packet (sent via email) for a detailed list of items you will need at camp. Below are just a few notes about some of the important things you will need for camp.

Allergens

Due to serious allergies, Camp Promise is a latex and peanut free zone. Please **do not** send any latex (e.g., gloves, balloons, etc.) or food with peanuts (e.g.: trail mix, candy, chocolate, etc.) to camp.

Clothes and Personal Items

Staff should pack enough clothing, personal items, and toiletries to last the entire camp session. Laundry will only be available for emergency purposes. We recommend packing layers to accommodate various types of weather. Please be sure to clearly mark and label all of your personal belongings prior to camp. Don't forget to refer to the Dress Code outlined in this handbook when selecting appropriate attire for camp.

- **NOTE:** You're going to camp, so you and your clothes will get dirty. It may be smart to pack a set of clothes you don't mind getting ruined in the mud pit or messy games.

Linens

You will need to provide your own sheets, blankets/sleeping bag, pillows and towels.

Costumes

We also encourage everyone to pack costumes and accessories to match each day's theme. Rest assured, you'll receive your Welcome Packet via email with a list of theme days with enough notice to stock up on your themed attire!

Medications

Please pack enough medicine for the entire duration of camp + two days. Remember, medications should NEVER be kept in cabins and campers should never have access to medications. While all staff medications must be stored at the nurse's stations for the week, staff will be able to self-administer their meds while at camp.

Interacting With Campers

How To Introduce Yourself To Campers

Many campers may not physically be able to reach out to shake your hand or give you a high-five. Here are some friendly and comfortable ways to introduce yourself to campers:

Dos:

- Smile.
- Make eye contact and talk directly to the camper.
- Put your hand in theirs if shaking their hand, or move your hand to theirs if fist bumping.
- Assume they're developmentally their biological age until you learn otherwise.
- Tell them who you are and how you're feeling, e.g., "Hi, I'm John. I've been so excited to meet you, and I'm so glad you're here!"
- Introduce them to others, such as another counselor or another camper who has already arrived.

Don'ts:

- Pat them on the head. This can make campers feel younger than they are.
- Hug them unless you ask permission first.
- Speak to their parents/guardians about them in third person.

Tips and Tricks

In order to successfully navigate camp, it is important to remember our following philosophies and guidelines:

1. TEAM APPROACH: Quality camper care is a team approach that involves all staff. This includes counselors, leadership staff, program specialists, and the medical staff. Work with the counselors in your cabin or the other staff on your team. Don't be afraid to ask for advice or help!
2. LANGUAGE GUIDES OUR ACTIONS: Person first language must always be used; our words lead our actions. If we chose to speak person first, we will treat our campers as individuals and not as disabilities or illnesses.
3. CAMPER INVOLVEMENT & EMPOWERMENT: We involved campers in their care, so ask what they need, and be respectful of their privacy. Remember—we do not do things *for* our campers, we do things *with* our campers. As an example, we do not feed campers, we eat with them. We do not push campers, we walk with them.

BE EQUITABLE: We do not show outward favoritism toward a camper or spend inequitable time with a certain camper. Please help campers interact with each other. Consider yourself a friendship facilitator.

Person-First Language

"The difference between the right word and the almost right word is the difference between lightning and the lightning bug." ~Mark Twain

Words are powerful. Inaccurate and inappropriate descriptors perpetuate negative stereotypes and attitudinal barriers. People first language puts the person before the disability, and it describes what a person has, not what a person is.

Are you "myopic" or do you wear glasses? Are you "cancerous" or do you have cancer? Are you "freckled" or do you have freckles? Are you "disabled" or do you have a disability?

Say:	**Instead of:**
People with disabilities.	The handicapped or disabled.
He has a cognitive disability.	He's mentally retarded.
She has autism.	She's Autistic.
She has a learning disability.	She's learning disabled.
He has a physical disability.	He's a quadriplegic/crippled.
She uses a wheelchair.	She's wheelchair bound/confined
He receives special ed. services.	He's in special ed.
Kids without disabilities.	Normal or healthy kids.
Accessible parking.	Handicapped parking.
She needs...or she uses...	She has a problem with...

The responsibilities of camp staff are quite multifaceted. It is not possible to have a set way to perform each task as different situations and the unique physical and emotional needs of the campers in each group will dictate the responsibilities and duties of each camp staff member.

The key points to focus on in this area are our camp values and philosophy. Please remember that our language and actions should exhibit that which we do with campers, not for campers. We strive to provide a holistically safe camp environment that considers the physical, emotional, and social safety needs and interests of each camper.

Information About Common Neuromuscular Diseases

“Neuromuscular disease” is a very broad term that encompasses many diseases that impair the functioning of the muscles, either directly (pathologies of the voluntary muscle), or indirectly (pathologies of nerves or neuromuscular junctions). These muscle-debilitating diseases take away physical strength, independence and life.

Muscular dystrophy is a group of inherited neuromuscular diseases that involve progressive muscle weakness and loss of muscle tissue that gets worse over time. Depending on the type of muscular dystrophy, all of the muscles may be affected or only a specific group of muscles may be affected (such as those around the pelvis, shoulder, or face). Muscular dystrophy can affect adults, but the more severe forms tend to occur in early childhood.

There are over 50 qualifying diagnoses for Camp Promise, but below are summaries of the most common primary diagnoses that our campers have. We welcome you to do further research on your camper’s specific diagnosis, but recommend that you pay most attention to the Implications For Recreation sections below to help you best understand how to help your camper in our recreational camp setting.

NOTE: Our goal for Camp Promise is to create a space where campers feel safe, supported, and free to make new friends and try new experiences. In order to do so, we ask that you refrain from discussing details of your camper’s diagnosis and prognosis at camp. Some campers may not know what their diagnosis or prognosis is, and we respect families’ rights to disclose this information to their children on their own schedule.

Primary Diagnoses

Acid maltase deficiency (Pompe disease, Glycogen Storage Disease)

Definition

Acid maltase deficiency is a metabolic muscle disorder, a group of diseases that interferes with the processing of food for energy production. This rare inherited neuromuscular disorder causes progressive muscle weakness in people of all ages.

There are several other names that doctors may use, that reflect either the specific enzyme deficiency or the glycogen substance involved in the disease:

- Pompe disease
- Glycogen storage disease (GSD) type II
- Glycogenosis type II
- Acid alpha-glucosidase deficiency
- Lysosomal alpha-glucosidase deficiency

Pompe disease is caused by a defective gene that results in a deficiency of an enzyme, acid alpha-glucosidase. The absence of this enzyme results in excessive buildup of a substance called glycogen, a form of sugar that is stored in a specialized compartment of muscle cells throughout the body.

Characteristics

This disease causes slowly progressive weakness, especially of the respiratory muscles and those of the hips, upper legs, shoulders and upper arms. Enlargement of the tongue and liver impairment occur in the infantile form, but rarely in the older-onset forms. Cardiac involvement may occur in the infantile or childhood forms but is less common in adults.

The childhood and adult-onset forms are milder than the infantile form, but may cause severe weakness and respiratory insufficiency, and, without treatment, shortened life span.

The progressive nature of the disease means that it always worsens over time, although the speed of this progression can vary from person to person.

Implications For Recreation

- Will likely use power wheelchair full time.
- Will need to be transferred in and out of chair and bed.
- Will need activities adapted to their specific abilities.
- Limited range of motion in their arms and legs.

References

www.pompe.com

Ataxia Telangiectasia (AT)

Definition

Ataxia-telangiectasia, also called “AT,” is a rare inherited disorder that affects the nervous system, immune system, and other body systems. This progressive, degenerative disorder is characterized by progressive degeneration of a part of the brain, known as the cerebellum, which gradually leads to a general lack of muscle control, and eventually confines the individual to a wheelchair. Progressive difficulty with coordinating movements (ataxia) begins in early childhood, usually before age five.

Characteristics

Not all features of the syndrome are present in all people with AT, and the severity of each symptom also varies a great deal from person to person.

The first signs of the disease usually appear early in childhood (the toddler stage), when children begin to walk. Though they usually start walking at a normal age, they wobble or sway when walking, standing still or sitting. In late preschool and early school age, children with AT develop difficulty moving the eyes in a natural manner from one place to the next.

Affected children typically develop difficulty walking, problems with balance and hand coordination, involuntary jerking movements, muscle twitches, and disturbances in nerve function. The movement problems typically cause people to require wheelchair assistance by adolescence. People with this disorder also have trouble moving their eyes to look side-to-side and may develop slurred or distorted speech and trouble swallowing.

Patients with AT have an increased susceptibility to infection. Due to their weakened immune system, many develop chronic lung infections. They also have an increased risk of developing cancer.

Other features of ataxia-telangiectasia that may affect some children are: diabetes mellitus, premature graying of the hair, difficulty swallowing causing choking and/or drooling and slowed growth. Even though AT is a multi-system disorder, most individuals with AT are very socially aware and socially skilled.

Implications For Recreation

- Will likely use wheelchair full time.
- May have slurred or slow speech, but this is a function of their facial muscles rather than their cognition, so don’t judge their developmental abilities based on their speech patterns.

- Muscle spasms may result in spastic, uncontrolled arm and leg movements. Be particularly aware of spasms when transferring camp.
- These spasms may also occur during one's sleep, so they may need a guardrail on their bed, or their legs wrapped tightly at night.

References

http://www.atcp.org
https://ghr.nlm.nih.gov/condition/ataxia-telangie

Becker muscular dystrophy (BMD)

Definition

Becker muscular dystrophy (BMD) is one of nine types of muscular dystrophy, a group of genetic, degenerative diseases primarily affecting voluntary muscles. BMD results from mutations in the dystrophin gene, the largest in the human genome. This gene typically codes for a protein called dystrophin that acts as a shock absorber or cushion for muscles. It binds to the muscle membrane and helps maintain the structure of muscle cells.

People with BMD make dystrophin that is partially functional and not in the normal amount. Without fully functional dystrophin, their muscle cells are easily damaged, may not operate properly, suffer progressive damage, and may eventually die.

BMD is a less severe form of Duchenne muscular dystrophy, which results from the total absence of dystrophin (see below). The shortened form of the dystrophin protein protects the muscles of those with BMD from degenerating as completely or as quickly as those of people with Duchenne, and allows the voluntary muscles to function better than they do for people with Duchenne.

BMD primarily affects boys and men, who inherit the disease through their mothers. Women can be carriers but usually exhibit no symptoms.

Characteristics

The pattern of muscle loss in BMD usually begins with the hips and pelvic area, the thighs and the shoulders. To compensate for weakening muscles, the person may walk with a waddling gait, walk on his toes or stick out the abdomen.

The rate of muscle degeneration varies a great deal from one person to another. Some men require wheelchairs by their 30s or later, while some manage for many years with minor aids, such as canes.

Because muscular dystrophy doesn’t affect nerves directly, touch and other senses remain normal, as does control over the smooth, or involuntary, muscles of the bladder and bowel, and sexual functions.

Muscle deterioration in BMD usually isn’t painful in itself. Some people report muscle cramps at times; these usually can be treated with over-the-counter pain relievers.

Like muscles in the limbs, heart muscles also can be weakened by lack of dystrophin. People with BMD often develop cardiomyopathy — heart muscle weakness — because of a deficiency of dystrophin. The muscle layer of the heart deteriorates, just as the skeletal muscles do.

Doctors believe that dystrophin abnormalities in the brain may cause subtle cognitive and behavioral deficits. The learning problems seen in some people with BMD seem to occur in three general areas: attention focusing, verbal learning and memory, and emotional interaction.

Damage done by BMD to the heart can become life-threatening as early as the teen years, and some people with BMD have mild skeletal muscle involvement but severe cardiac problems. Respiratory muscles often stay strong in BMD for many years, but eventually, they may become weaker than is optimal for breathing and coughing (to clear secretions from the respiratory tract).

Implications For Recreation

- May maintain ambulation (their ability to walk) into their twenties, but may have a slower or different gait.
- May not be able to run and may require adaptations when playing sports.
- May have learning disabilities.
- Commonly typically developed and at age level.

References

www.mda.org

Charcot-Marie-Tooth disease (CMT)

Definition

CMT is the most commonly inherited peripheral nerve disorder affecting about 1 in 2,500 people. CMT causes damage to the peripheral nerves, which carry signals from the brain and spinal cord to the muscles, and relay sensations, such as pain and touch, to the brain and spinal cord from the rest of the body.

CMT is caused by defects in the genes for proteins that affect axons — fibers that carry electrical signals between the brain and spinal cord and the rest of the body — or in the genes for proteins that affect myelin, a coating on axons that insulates and nourishes them.

There are a number of types of CMT. Depending on the type of CMT, onset can be from birth to adulthood, and progression is generally slow. CMT usually isn't life-threatening, and it almost never affects the brain.

Characteristics

CMT causes muscle weakness and atrophy, and some loss of sensation in the feet, the lower legs, the hands and the forearms. It also often causes contractures (stiffened joints due to abnormal tightening of muscles and associated tissues), and sometimes, curvature of the spine (scoliosis).

At the severe end of the CMT spectrum, the disease can affect nerves other than those that go to and from the extremities. If the nerves that go to and from the diaphragm or intercostal (between the ribs) muscles are affected, respiratory impairment can result.

Implications For Recreation

- Teen campers may use a scooter for long distances, while older campers will likely use power wheelchairs full time.
- Depending on age and state of disease progression, may be able to self-transfer themselves in and out of chair/bed, or may need to be transferred by their counselor.
- May have high pain levels.
- Will need activities adapted to their specific abilities.
- Limited range of motion in their arms and legs.

References

www.mda.org

Congenital muscular dystrophy (CMD)

Definition

Congenital muscular dystrophy (CMD) is a general term for a group of genetic muscle diseases that occur at birth (congenital) or early during infancy (typically before age two). CMD is caused by genetic mutations affecting some of the proteins necessary for muscles and sometimes for the eyes and or brain.

CMD has its onset at or near birth, and progression varies with type. Many types are slowly progressive; some shorten life span.

Characteristics

Most children with CMD exhibit some progressive muscle weakness, although they can have different symptoms, degrees of severity and rates of progression. This weakness, usually first identified as hypotonia, or lack of muscle tone, can make an infant seem “floppy.” Later, infants and toddlers may be slow to meet motor milestones such as rolling over, sitting up or walking, or may not meet some milestones at all.

CMDs are generally characterized by hypotonia, which is sometimes referred to as "floppy baby;” progressive muscle weakness and degeneration (atrophy); abnormally fixed joints that occur when thickening and shortening of tissue such as muscle fibers cause deformity and restrict the movement of an affected area (contractures); spinal rigidity, and delays in reaching motor milestones such as sitting or standing unassisted.

CMD results in overall muscle weakness with possible joint stiffness or looseness. Muscle weakness may improve, remain stable or worsen. Depending on the type, CMD may involve spinal curvature, respiratory insufficiency, intellectual disabilities, learning disabilities, eye defects or seizures. Feeding difficulties and breathing (respiratory) complications can develop in some cases. Some of the rarer forms of CMD are also accompanied by structural brain defects, significant learning disabilities, or developmental disabilities.

The severity, specific symptoms, and progression of these disorders vary greatly and no two individuals are the same.

Implications For Recreation

- Will likely use a power wheelchair full time.
- May need to be transferred in and out of bed/chair.
- Will need activities adapted to their specific abilities.
- Limited range of motion in their arms and legs.

References

www.rarediseases.org
www.mda.org

Duchenne muscular dystrophy (DMD)

Definition

Duchenne muscular dystrophy is the most common fatal childhood genetic disorder, affecting approximately 1 in every 3,500 live male births.

Duchenne results from mutations in the *dystrophin* gene (the largest gene in the human genome) that codes for a protein called dystrophin. In a healthy body, this protein acts as a shock absorber or cushion for muscles. It binds to the muscle membrane and helps maintain the structure of muscle cells. Those with Duchenne do not make the dystrophin protein at all. Because dystrophin is absent in those with Duchenne, the muscle cells are easily damaged, and the muscles are unable to operate properly, suffer progressive damage, and eventually die.

Becker muscular dystrophy, which is less severe than Duchenne, occurs when dystrophin is manufactured, but not in the normal form or amount.

Because the Duchenne gene is found on the X-chromosome, it primarily affects boys; however, it occurs across all races and cultures. Duchenne can be passed from parent to child, but approximately one third of cases occur because of a random spontaneous mutation. In other words, it can affect anyone. Although there are medical treatments that may help slow its progression, there is currently no cure for Duchenne and young men with Duchenne typically live into their late twenties.

Characteristics

Although the progression and severity of each case is different, there are four generally recognized stages of Duchenne.

Early Phase (diagnosis to age 7):

Duchenne is typically diagnosed between the ages of two and seven. Boys with Duchenne may develop later than children of the same age—many times there will be delays in early developmental milestones such as sitting, walking, and/or talking. Speech delay and/or the inability to keep up with peers will often be the first signs of the disorder.

Physical symptoms:

- Will typically move slower or with more difficulty than other children of the same age.
- May appear clumsy and fall frequently, and may have difficulty climbing, jumping, or running.
- Because of muscle weakness, may become tired more easily, or will have low energy.
- May ask to be carried frequently, or need the use of a stroller for longer distances.

- Some muscles (in particular the calves) may appear enlarged or overdeveloped. This enlargement is known as pseudohypertrophy, or "false enlargement," because the muscle tissue is abnormal and happens because muscle cells are being replaced by scar tissue.
- Flat feet and tight heel cords can prevent them from flexing their ankles, so they may walk on their toes. This impacts their balance, causes them to have a swayed back, and they may roll over their foot while walking.
- Decrease flexibility from having lost elasticity in the joints (also known as contractures).

Transitional Phase (ages 6 to 9)

A child with Duchenne will have more and more difficulty walking as their quadriceps (muscles in the front of the thighs) grow weaker. This throws off their balance and boys will often shift their weight while walking. It is common for them to walk on the balls of their feet or toes to help stay balanced.

In order to compensate for weak trunk muscles, a boy with Duchenne may stick out his belly and throw his shoulders back as he walks. When asked to stand up, he will put his bottom up in the air first and use his arms for support by “walking” his arms up his legs with his hands until he is standing (also known as the “Gower maneuver”).

Most boys at this age maintain the use of their hands and arms, but may have difficulty carrying their books and other school materials (even when using a backpack). In general, fatigue is common at this stage and they may need the use of a stroller, lightweight wheelchair, or electric scooter for longer distances. Some children may use a walker to assist them in getting around school.

Loss of Ambulation (ages 10 to 14)

The “tween” and teen years bring a continuous progression of muscle weakness. Typically, boys with Duchenne lose their ability to walk between the ages of ten and fourteen and need to use a power wheelchair on a regular basis. Activities involving the arms, legs, or trunk will require assistance or mechanical support. Not surprisingly, fatigue is quite common.

Beginning at about 10 years of age, the diaphragm and other muscles that operate the lungs may also weaken, making the lungs less effective at moving air in and out. Although the child may not complain of shortness of breath, problems that indicate poor respiratory function include headaches, mental dullness, difficulty concentrating or staying awake, and nightmares.

Because they have weak back muscles and are seated much of the day, they may begin to develop symptoms of scoliosis. The scoliosis, as well as muscle cramps, may result in some physical discomfort at times.

Weakness in the arms can make activities of daily living more difficult. Most young men, however, will retain the use of their fingers through this phase, so they can generally still write or use a computer.

Adult Stage (ages 15+)

By their late teens, young men with Duchenne lose the strength in their upper bodies, including the ability to move their arms. They often maintain the muscles in their fingers, which allows them to continue driving their wheelchairs via joystick.

Also during their teenage years, their breathing or respiratory systems weaken and young men with Duchenne usually need help with breathing at night. Weakened respiratory muscles make it difficult to cough, leading to increased risk of serious respiratory infection, and a simple cold can quickly progress to pneumonia. Some may need respiratory therapy including ventilators or tracheostomies.

Life-threatening cardiac and respiratory conditions eventually occur and may start as early or during the teenage years. Major symptoms of heart and lung complications include shortness of breath, fluid in the lungs, and swelling in the feet and lower legs. Young men with Duchenne typically live into their twenties or early thirties.

Pain and Sensation

The muscle deterioration in Duchenne isn't usually painful in itself. Some people report muscle cramps at times; these usually can be treated with over-the-counter pain relievers. And, because muscular dystrophy doesn't affect nerves directly, touch and other senses are normal, as is control over the smooth, or involuntary, muscles of the bladder and bowel, and sexual functions.

Dystrophin and the Brain

About a third of boys with DMD have some degree of learning disability, although few have serious developmental disabilities. Doctors believe that dystrophin abnormalities in the brain may have subtle effects on cognition and behavior. Learning problems in DMD occur in three general areas: attention focusing, verbal learning and memory, and emotional interaction. Executive functioning and impulse control may also be impacted.

Implications for Recreation

- Younger campers may be able to walk, but may use a scooter or stroller for going long distances. They will tire easily because they're more active at camp than they are at home, and because our camp facilities are large, they cover more ground at camp than they do at home. They may also fall easily, especially when their muscles are tired, and may have difficulty:
    - Climbing upstairs or walking uphill.
    - Getting up from the ground.
    - Getting up off a chair.

    - Raising their arms overhead and getting dressed
- Teens will most likely use power wheelchairs and will need assistance being transferred to and from their wheelchair. They may have the use of their arms and be able to feed themselves with assistance.
- Young adult campers will need help with all of their daily activities of living, such as eating, brushing their teeth, getting dressed, using the bathroom, and person hygiene. Some campers may use equipment to help them breathe, each, or use the bathroom with greater ease.
- Many campers may have heart failure, but it's important to note that heart failure occurs when the heart fails to meet the demands of the body. "Heart failure" doesn't mean the heart has stopped. So, while many campers may have heart function that would be near-deadly for a typical person, just remember that they are less active and have less demands on their heart compared to a healthy person.
- To provide healthy heart care at camp:
    - Keep your camper hydrated.
    - Don't leave your camper alone.
    - Know your camper's baseline.
    - Keep an eye out for swelling feet or overall puffiness.
    - If a camper complains of heart racing or a skipping beat, go see the nurse.
    - If a camper complains of chest pain, go see the nurse.

References

www.mda.org
www.parentprojectmd.org

Friedreich's Ataxia (FA)

Definition

Friedreich's ataxia (FA) is a debilitating, life-shortening, degenerative neuro-muscular disorder. About one in 50,000 people in the United States have FA and it is caused by mutations in the FXN gene. Mutations of the FXN gene limits the production of a protein called frataxin. Frataxin is known to be an important protein that functions in the mitochondria of the cell. Frataxin helps to move iron and is involved with the formation of iron-sulfur clusters, which are necessary components in the function of the mitochondria and thus energy production. FA also results in neuron degeneration and this is directly manifested in the symptoms of the disease.

FA is inherited in an autosomal recessive manner, meaning that individuals with FA have two mutated copies of the FXN gene and received one mutated copy of the gene from each of their biological parents. It is estimated that 1 in 100 people are carriers, and carriers do not exhibit symptoms of FA.

Characteristics

Most individuals have onset of symptoms of FA between the ages of 5 and 18 years. Adult or late onset FA is less common (<25% of diagnosed individuals), and can occur anytime during adulthood. Signs and symptoms of FA include:

- Loss of coordination (ataxia) in the arms and legs.
- Fatigue, energy deprivation and muscle loss
- Vision impairment, hearing loss, and slurred speech.
- Aggressive scoliosis (curvature of the spine).
- Diabetes mellitus (insulin - dependent, in most cases).
- Serious heart conditions, including hypertrophic cardiomyopathy and arrhythmias.

These symptoms are not present in all individuals with FA, for example diabetes occurs in about 10-20% of individuals with FA. The mental capabilities of people with Friedreich's ataxia remain completely intact. The progressive loss of coordination and muscle strength leads to mobility impairments and the full-time use of a wheelchair. Most young people diagnosed with FA require mobility aids such as a cane, walker, or wheelchair by their teens or early 20s.

Implications For Recreation

- Will likely use wheelchair full time.
- May have slurred or slow speech, but this is a function of their facial muscles rather than their cognition, so don't judge their developmental abilities based on their speech patterns. Remember, their mental capabilities remain intact.
- May have hearing loss, so you may need to speak loudly or assist with hearing aids.

Muscle spasms may result in spastic, uncontrolled arm and leg movements. Be particularly aware of spasms when transferring camper.

- These spasms may also occur during one's sleep, so they may need a guardrail on their bed, or their legs wrapped tightly at night.

References:

www.curefa.org

Limb-girdle muscular dystrophy (LGMD)

Definition

Limb-girdle muscular dystrophy (LGMD) is a group of disorders affecting voluntary muscles, mainly those around the hips and shoulders. The shoulder girdle is the bony structure that surrounds the shoulder area, and the pelvic girdle is the bony structure surrounding the hips. Collectively, these are called the limb girdles, and it is the muscles connected to the limb girdles that are the most affected in LGMD.

Like other muscular dystrophies, LGMD is primarily a disorder of voluntary muscles. These are the muscles you use to move the limbs, neck, trunk and other parts of the body that are under voluntary control.

There are at least 19 forms of LGMD that result from a mutation in any of at least 15 different genes that affect proteins necessary for muscle function. Some types are autosomal dominant, meaning LGMD is inherited from one parent. Other types are autosomal recessive and occur when a faulty gene is inherited from each parent. Both genders are affected equally.

Characteristics

LGMD can begin in childhood, adolescence, young adulthood or even later. When limb-girdle muscular dystrophy begins in childhood, the progression is usually faster and the disease more disabling. When the disorder begins in adolescence or adulthood, it's generally not as severe and progresses more slowly.

Often, people with LGMD first notice a problem when they begin to walk with a "waddling" gait because of weakness of the hip and leg muscles. They may have trouble getting out of chairs, rising from a toilet seat or climbing stairs.

Over time, muscle weakness and atrophy can lead to limited mobility and an inability to raise the arms above the shoulders. Weakness in the shoulder area may make reaching over the head, holding the arms outstretched or carrying heavy objects difficult. It may become increasingly hard to keep the arms above the head for such activities as combing your hair or arranging things on a high shelf. Some people find it harder to type on a computer or other keyboard and may even have trouble feeding themselves. Assistive devices, such as a cane or a long-handled reacher, can make things easier as weakness progresses.

Some forms of the disorder progress to loss of walking ability within a few years and cause serious disability, while others progress very slowly over many years and cause minimal disability. A power wheelchair or scooter becomes convenient when weakness in the pelvic girdle and upper legs causes frequent falls. People whose LGMD has reached this stage often find that a great deal of their independence returns, and they're much less fatigued, when they begin using this type of vehicle.

The involuntary muscles, except for the heart (which is a special type of involuntary muscle), are not affected in LGMD. Digestive, bowel, bladder and sexual function remain normal. The brain, intellect and senses also are unaffected in LGMD. Cardiopulmonary complications, including cardiomyopathy (weakness of the heart muscle) or arrhythmias (abnormal transmission of signals that regulate the heartbeat) sometimes occur in later stages of the disease.

Misc:

- Respiratory (breathing) function can decline over time.
- Pain isn't a major part of LGMD, although limited mobility sometimes leads to muscle soreness and aching joints.
- Exercises to keep joints limber, moving around as much as possible, warm baths and sometimes medication can keep discomfort to a minimum.
- The brain, the intellect and the senses are unaffected in LGMD. People with LGMD can think, see, hear and feel sensations just as well as those without muscular dystrophy.

Implications For Recreation

- May maintain ambulation (their ability to walk) into their twenties, but may have a slower or different gait.
- If ambulatory, may not be able to run and may require adaptations when playing sports, or may use a scooter for long distances.
- Commonly typically developed and at age level.

References

www.mda.org

Myotonic muscular dystrophy (DM)

Definition

Myotonic muscular dystrophy (MMD) is a form of muscular dystrophy that affects muscles and many other organs in the body. The word myotonic is the adjective for the word myotonia, an inability to relax muscles at will. The term muscular dystrophy means progressive muscle degeneration, with weakness and shrinkage of the muscle tissue.

MMD causes weakness of the voluntary muscles, although the degree of weakness and the muscles most affected vary greatly according to the type of MMD and the age of the person with the disorder.

There are two types of MMD:

1. Type 1 (MMD1) occurs when a gene on chromosome 19 called DMPK contains an abnormally expanded section. Within MMD1 there are additional subtypes, depending on a person's age at onset of symptoms. The age of onset is roughly correlated with the size of the DNA expansion, with larger expansions associated with earlier disease onset. The subtypes of MMD1 are:
    a. Congenital-onset MMD1: Begins at or around the time of birth and is characterized by severe muscle weakness, cognitive impairment and other developmental abnormalities
    b. Juvenile-onset MMD1: Begins during childhood (after birth but before adolescence) and is characterized by cognitive and behavioral symptoms, muscle weakness, myotonia (difficulty relaxing muscles after use) and other symptoms.
    c. Adult-onset MMD1: Begins in adolescence or early adulthood and is characterized by slowly progressive weakness, myotonia, cardiac abnormalities and, sometimes, mild to moderate cognitive difficulties.
2. Type 2 (MMD2) is caused by an abnormally expanded section in a gene on chromosome 3 called ZNF9.

Both MMD1 and MMD2 are inherited in an autosomal dominant pattern, meaning it takes only one flawed gene to cause symptoms of the disease. If one parent has the disorder, every child of that person has a 50 percent chance of inheriting the gene flaw that causes it. Genetic testing for the expanded DNA that leads to either type of MMD can be performed.

Characteristics

Myotonia, the inability to relax muscles at will, is a primary feature of MMD. For example, it may be difficult for someone with MMD to let go of someone's hand after shaking it. Overall, the progression of MMD varies greatly among individuals, but in general, symptoms progress slowly. As the disease progresses, the heart can develop an abnormal rhythm and the heart muscle can weaken. The muscles used for breathing can weaken, causing inadequate breathing, particularly during sleep. The development

of Cataracts (opaque spots in the lenses of the eyes) relatively early in life are another characteristic of MMD, in both type 1 and type 2.

Overall intelligence is typically normal in people with MMD, but learning disabilities and an apathetic demeanor are common in the Type 1 form. In congenital MMD1, which affects children from the time of birth, there can be serious impairment of cognitive functioning. These children also may have problems with speech, hearing and vision.

Type 1

The most common type of MMD1 — the "adult-onset" form — begins in adolescence or young adulthood, often with weakness in the muscles of the face, neck, fingers and ankles. The weakness is slowly progressive for these and eventually other muscles. Generally, the earlier MMD1 begins, the more profound the symptoms tend to be. In Type 1 MMD, the involuntary muscles, such as those of the gastrointestinal tract, can be affected. Difficulty swallowing, constipation and gallstones can occur. In females, the muscles of the uterus can behave abnormally, leading to complications in pregnancy and labor.

When MMD1 begins earlier in life than adolescence — the congenital-onset and juvenile-onset forms of the disease — it may be quite different in progression from the adult-onset type. Children with congenital-onset MMD1, once they survive the crucial neonatal period of respiratory muscle weakness with the help of assisted ventilation, usually show improvements in motor and breathing functions over the first year or so. They may have cognitive impairment, delayed speech, difficulty eating and drinking and various other developmental delays. Most will learn to walk. As adolescence approaches, children begin to show symptoms of the adult-onset form of MMD1 and follow its usual progression.

The childhood-onset form of MMD1 — beginning after infancy but before adolescence — is more often characterized by cognitive and behavioral disabilities than by physical disabilities. Eventually, muscle symptoms develop, to varying degrees.

Type 2

MMD2 is, in general, a milder disease than type 1. It does not appear to have a congenital-onset form and rarely begins in childhood. In contrast to type 1 MMD, the muscles affected first in MMD2 are the proximal muscles — those close to the center of the body — particularly those around the hips. However, some finger weakness may be seen early as well. The disorder progresses slowly, but mobility may be impaired early because of weakness of the large, weight-bearing muscles.

MMD2 is quite rare, except in Germany and in people of German descent. Not as much is known about MMD2 as about MMD1.

Implications For Recreation

- Often ambulatory with a slow or different gait, or may use a scooter or manual wheelchair.
- If ambulatory, may not be able to run and may require adaptations when playing sports.
- May have learning disabilities or exhibit forms of developmental disabilities.
- Commonly affects facial muscle so may not emote.

References

www.mda.org

Spinal muscular atrophy (SMA)

Definition

Spinal muscular atrophy (SMA) is a genetic disease affecting the part of the nervous system that controls voluntary muscle movement. SMA involves the loss of nerve cells called motor neurons in the spinal cord and is classified as a motor neuron disease.

SMA is caused by a mutation on chromosome 5 in a gene called SMN1, resulting in a deficiency of a motor neuron protein called SMN, for “survival of motor neuron.” This protein, as its name implies, seems to be necessary for normal motor neuron function. Other more rare forms of SMA (non-chromosome 5) are caused by mutations in genes besides SMN.

Characteristics

The primary symptom of SMA is weakness of the voluntary muscles. The muscles most affected are those closest to the center of the body, such as those of the shoulders, hips, thighs and upper back. Special complications occur if the muscles used for breathing and swallowing are affected, resulting in abnormalities in these functions. If the muscles of the back weaken, spinal curvatures can develop. Sensory, mental and emotional functioning are entirely normal in SMA.

There is wide variability in age of onset, symptoms and rate of progression. Symptoms vary based on how much SMN protein there is in the motor neurons. The more SMN protein there is, the later in life symptoms begin and the milder the course of the disease is likely to be. The earlier the age of onset, the greater the impact on motor function. SMA is classified into four types ranging from severe to mild:

- Type 1: Children who have noticeable SMA symptoms at or shortly after birth usually have the lowest level of functioning and are very weak, have difficulty breathing, sucking and swallowing, and never reach the developmental milestone of being able to sit on their own (type 1 SMA or Werdnig-Hoffmann disease). In the past, children with type 1 SMA usually didn't survive more than two years, but today this is not always the case. With technology such as mechanical ventilation and feeding tubes to assist with breathing and nutrition, children with type 1 SMA can survive for a number of years.
- Types 2: When SMA symptoms begin in babies at approximately 7 to 18 months of age, who learn to sit unassisted but not to stand or walk independently, the disease usually is called type 2 SMA, or intermediate SMA. Although respiratory complications are a constant threat, children with type 2 SMA usually live to young adulthood and many live longer.
- Type 3: When muscle weakness begins in older children and teens, who learn to stand and walk but lose the ability later in life, the disease may be labeled type 3 SMA (also known as mild SMA and Kugelberg-Welander disease). Although some with type 3 stop walking in adolescence, others walk well into their adult years.
- Type 4: SMA that comes on in late teens or adulthood is called type 4, or adult-onset SMA. These individuals maintain higher levels of motor function and they maintain a normal life space.

In SMA types 1 through 4, the muscles closer to the center of the body usually are more affected, or at least affected much sooner, than the muscles farther away from the center. For example, the muscles of the thighs are weaker than the muscles of the lower legs and feet. Legs tend to weaken before arms. Hands may weaken eventually, but they usually stay strongest the longest, and, even if they do weaken, they usually remain strong enough for typing on a computer keyboard and other basic functions of modern life.

The most serious danger in SMA comes from the weakness of muscles necessary for breathing. Another medical complication in SMA is spinal curvature, usually a side-to-side type of curvature called scoliosis. Scoliosis can be very uncomfortable, interfere with position and mobility and damage an individual’s body image.

Implications For Recreation

- Will likely use a power wheelchair full-time.
- May use body brace to treat scoliosis, which can be hot and uncomfortable in the summer heat.
- May use assistive respiratory devices during the day and/or at night, such a bi- pap or sip & puff.

References

www.mda.org

Secondary Diagnoses

Many campers may have secondary diagnoses or behavioral patterns that will impact the care they need. Please familiarize yourself with the following conditions as your camper, a camper in your cabin, or a camper elsewhere at camp may experience any of the following.

Use the following as a general guide to learn more about a disability and the techniques that you can use when working with a camper who has that disability.

Anxiety Disorder

Definition

Anxiety is a normal reaction to stress and can actually be beneficial in some situations. For some people, however, anxiety can become excessive. While the person suffering may realize their anxiety is too much, they may also have difficulty controlling it and it may negatively affect their day-to-day living. There are a wide variety of anxiety disorders, including post-traumatic stress disorder, obsessive- compulsive disorder, and panic disorder to name a few. Collectively, they are among the most common mental disorders experienced by Americans.

The following anxiety disorders are examples of Anxiety Disorders:

1. Generalized Anxiety Disorder (GAD)
2. Obsessive-compulsive Disorder (OCD)
    - An anxiety disorder in which the individual has recurrent and persistent thoughts or ideas that may be quite bizarre but cannot be suppressed, even when the individual is aware of their inappropriate nature. Thoughts are often associated with compulsive behaviors or repetitive rituals, such as compulsive touching or excessive hand washing.
3. Panic Disorder
    - An anxiety disorder associated with feelings of emotional uneasiness, a sense of anticipated danger, excessive fear, general anxiety, and excessive vigilance.

4. Post-Traumatic Stress Disorder (PTSD)
5. Separation Anxiety Disorder

- Separation anxiety disorder almost always occurs in children. It is suspected in children who are excessively anxious about separation from important family members or from home. For a diagnosis of separation anxiety disorder, the child should also exhibit at least three of the following symptoms for at least 4 weeks:
- Extreme distress from either anticipating or actually being away from home or being separated from a parent or other loved one
- Extreme worry about losing or about possible harm befalling a loved one

Characteristics

There are common risk factors that often prelude an anxiety disorder:

- Gender. With the exception of obsessive-compulsive disorder (OCD), women have twice the risk for most anxiety disorders as men.
- Age. Phobias, OCD, and separation anxiety typically show up early in childhood, while social phobia and panic disorder often develop during the teen years.
- Traumatic Events. Traumatic events can trigger anxiety disorders, particularly post-traumatic stress disorder.
- Medical Conditions. Although causal relationships have not been established, certain medical conditions have been associated with increased risk of panic disorder. They include migraines, obstructive sleep apnea, mitral valve prolapse, irritable bowel syndrome, chronic fatigue syndrome, and premenstrual syndrome.

Implications for Recreation

- Campers with anxiety disorders may have a hard time arriving at camp daily.
- Campers may have debilitating anxiety if asked to try new activities.
- Provide campers with schedules.
- Make campers aware of transitions or changes in the schedule.
- Help the child feel safe and when possible, distract them with a preferred activity.
- Do not caudle or allow them to remain removed from the activities – this only allows for more focus on the anxiety.
- Find roles within the activities that they are comfortable doing (keeping score, helping set up, having a partner, etc.).
- Provide feedback to the individual on how they are doing.
- Clear, concise, instructions regarding his/her responsibilities and how various tasks should be undertaken.

Attention Deficit Hyperactivity Disorder (ADHD)

Definition

Attention-Deficit Hyperactivity Disorder (ADHD) is a neurobiological disorder. Typically, children with ADHD have developmentally inappropriate behavior, including poor attention skills, impulsivity, and hyperactivity. These characteristics arise in childhood, typically before the age of 7, are chronic, and last for at least six months. Scientific evidence suggests that ADHD is genetically transmitted and in many cases results from a chemical imbalance or deficiency in certain neurotransmitters, which are chemicals that help the brain regulate behavior.

Characteristics

ADHD involves significant deficits in sustained attention, impulsivity, motor activity, inhibition of behavior, and self-control or regulation of activity level that are developmentally appropriate for the child's age. This disorder also inhibits the ability to follow rules and monitor his/her own behavior. Often persons with ADHD have a difficult time working on long-term goals and require constant redirection and verbal, as well as visual cues to enable them to attend to the immediate task at hand.

Implications for Recreation

By establishing structure and routines, program staff can cultivate an environment that encourages the child to control his or her behavior and success at learning. Adaptations that might be helpful include:

- Posting daily schedules and assignments.
- Calling attention to schedule changes.
- Provide the camper with a sensory toy or fidget.
- Setting specific times for specific tasks.
- Designing a quiet space for use upon request.
- Providing regularly scheduled and frequent breaks.
- Supplementing verbal instructions with visual instructions.
- Allow changes that do not affect the entire group dynamic – a child can stand and listen to instructions!
- Lines do not have to be perfectly straight

Autism Spectrum Disorders (ASD)

Definition

Autism and Pervasive Developmental Disorder – NOS (not otherwise specified) are developmental disabilities that share many of the same characteristics. Usually evident by age three, autism and PDD-NOS are neurological disorders that affect a child's ability to communicate, understand language, play and relate to others.

A diagnosis of autism is made when an individual displays 6 or more of the 12 symptoms listed across 3 major areas: social interaction, communication, and behavior. When children display similar behaviors, but do not meet the criteria for autistic disorder, they may receive a diagnosis of Pervasive Developmental Disorder-NOS (PPD-NOS). Although the diagnosis is referred to as PDD-NOS, throughout the remainder of this fact sheet, we will refer to the diagnosis as PDD, as it is commonly known.

Characteristics

These disorders are four times more common in boys than in girls. The specific cause for autism and PDD are unknown. Current research links autism to biological or neurological differences in the brain. Some or all of the following characteristics may be observed in mild to severe form:

- Communication challenges (e.g., using and understanding verbal and nonverbal language).
- Difficulty relating to people, objects, and events.
- Unusual play with toys and other objects.
- Difficulty with changes in routine or familiar surroundings.
- Repetitive body movements or behavior patterns.

Children with autism or PDD vary widely in abilities, intelligence, and behaviors. Some children do not speak; others have language that often includes repeated phrases or conversations. Persons with more advanced language skills tend to use a small range of topics and have difficulty with abstract concepts. Repetitive play skills, a limited range of interests, and impaired social skills are generally evident as well. Unusual responses to sensory information many include: loud noises, lights, certain textures or food or fabric. Furthermore, some children with autism or PDD may respond negatively, and sometimes, aggressively to being touched.

Implications for Recreation

Although adaptations to equipment and programs are seldom necessary, there are some strategies that will help the individual be more successful in an activity/program.

These include, but are not limited to the following:

- Structure the activity so that tasks are specific, clear, and easily accomplished.
- Help facilitate interactions and friendships.

- Present information or instructions with visual cues, as well as verbal.
- Prepare for transitions by announcing the change of activities before it happens
- Model appropriate social behaviors.
- Give vocabulary for common social interactions (i.e., “please”, “hello,” etc.) and encourage use of language.
- Demonstrate and encourage the appropriate use of objects and equipment
- Provide clear expectations about behavior and give verbal cue (i.e., “keep hands to yourself,” “walk,” “eyes on me,” “hands down.”).
- Be patient and give lots of positive feedback.
- Help to develop new leisure skills based on the existing skills and interests of the individual.

Developmental Disabilities

Developmental disability means a severe, chronic disability of a person which: (a) is attributed to a mental or physical disability or a combination thereof, (b) is manifested before the person attains age eighteen, (c) is likely to continue indefinitely, (d) results in substantial functional limitations in three or more of the following areas of major life activity:

1. Learning: ability to recognize colors, shapes, letters, words, foods, etc.
2. Reception and expressive language: ability to talk and/or express oneself, ability to understand and follow simple directives.
3. Self-direction: ability to make decision or do what is expected.
4. Capacity of independent living: ability to exist independently.
5. Self-care: ability to dress oneself, brush teeth, toilet, etc.
6. Mobility: ability to move in a manner that is acceptable, such as: walking, running, sitting, etc.
7. Economic self-sufficiency: ability to partially support themselves.

And (e) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of life-long or extended duration and are individually planned and coordinated.

Developmental disabilities are the life-time conditions of mental impairment, cerebral palsy, epilepsy, autism, and severe dyslexia.

Diabetes

Diabetes mellitus is a condition where the body cannot maintain normal blood glucose levels. Glucose is the main source of fuel for the body and is made by breaking down carbohydrates.

Insulin is a hormone that helps glucose move from the blood into the cells. When the body does not produce enough insulin, the cells cannot use glucose and the blood glucose level rises.

Diabetes may be controlled through diet, medication, or a combination of both. If a camper in your cabin has diabetes, coordinate their mealtime needs with the Camp Nurse and make sure you understand what food they are allowed to eat (especially when it comes to desserts and snacks).

Hearing Impairment

Definition

Hearing impairment is the general term used to describe and encompass all types of hearing defects ranging from a very minimal loss to profound deafness. A hearing impairment may be congenital or the result of an accident or illness. It may also be caused by prolonged exposure to excessive levels of noise. Whatever the cause, the presence of a hearing impairment implies a breakdown in the physiological mechanisms of hearing.

Deafness refers to a hearing loss so severe that with or without an assistive hearing device, a person cannot always depend upon hearing to communicate with others. Anyone who becomes deaf after the age of seven usually has ordinary language and vocabulary skills. On the other hand, those who become deaf at an earlier age may have vocabulary, which may cause some difficulty with communication. The term hard of hearing refers to a condition where the sense of hearing is defective but functional for ordinary life purposes (sometimes with the help of a hearing aid).

Characteristics

Hearing impairments are classified as mild, moderate, or severe based on the degree of hearing loss as measured in decibels. A decibel is a unit used to measure the loudness of sounds. It is based on the smallest change that an acute human ear can hear. A sound of zero decibels is the softest sound. Ordinary conversations are measured at 60-80 decibels. The following illustrated the various degree and effects of hearing loss:

- Mild: the person has 20 to 30 decibel loss. They do not experience too many problems in learning but may need preferential seating (front row) and may or may not have a hearing aid.
- Marginal: 30 to 40 decibel loss. Cannot hear conversational speech at a distance further that three feet and may miss as much as fifty percent of instruction if they cannot see the lips of the speaker. May have slight speech defect.
- Moderate: 40 to 60 decibel loss. Can hear loud conversations within the three foot range, but often misunderstands meanings. May be incorrectly labeled as slow or as a behavior problem. Has defective speech and may not hear clearly even with hearing aids.
- Severe: 60-75 decibel loss. Considered partially or educationally deaf. With hearing aid, can hear loud noises and words spoken several inches from the ear. May require special training to speak.
- Profound: 75 or greater decibel loss. Considered totally deaf and cannot hear words event with amplification. May be able to distinguish some noises from others if close by. Responds reflexivity to loud sounds close to ear by turning head or blinking eyes. Responds to music and dance by recognizing the presence of vibrations.

Implications for Recreation

Communication difficulties can be minimized either by the use of a hearing aid (for those who are partially deaf) or by leaders using visual demonstration with simpler words and sentences. Training may take a little time but once the recreation skill has been learned by the person with a hearing impairment, his/her participation will be typical. To facilitate speech-readying, the instructor should be sure to turn towards the light and face the listener, speak clearly and in a normal tone, use facial expressions, hand gestures, and body movements to aid communication. Avoid background noise if necessary. If participants are participating in watersports, make sure that they take their hearing aids out so they do not get wet.

Including Individuals with hearing impairments:

- Be sure to have the listener's attention (light touch, wave, or other visual sign if needed to attract his/her attention).
- Turn toward the light and face the listener (keep the sun out of the listener's eyes).
- Speak clearly and slowly.
- Use a normal tone of voice. Avoid shouting or exaggerated expressions.
- Use facial expressions, hand gestures, and body movements to aid communication.
- Avoid chewing while your talk. Be aware that mustaches and beards can be a barrier to lip reading.
- Many people with hearing impairments do not read lips so do not rely on that as a sole means of communication.
- Avoid background noise (if possible).
- Use simple sentences and directions to get over a stumbling block. Try to rephrase or use different words.
- Look for signs of "bluffing." The person may be embarrassed and pretend to hear what you said.
- Be patient and understanding

Learning Disabilities

Definitions

The regulations for Public Law (P.L._101-476 the Individuals with Disabilities Education Act) defines a learning disability as a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations.

The federal definition further states that learning disabilities include such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. According to the law, learning disabilities do not include learning problems that are primarily the result of visual, hearing, or motor disabilities, mental retardation, or environmental, cultural, or economic disadvantage. Definitions of learning disabilities also vary among states.

Characteristics

Learning disabilities are characterized by a significant difference in the child's achievement in some area, as compared to his or her overall intelligence.

Individuals who have learning disabilities may exhibit a wide range of traits, including problems with reading comprehension, spoken language, writing, or reasoning ability. Hyperactivity, inattention, and perceptual coordination problems may also be associated with learning disabilities. Other traits that may be present include a variety of symptoms, such as perceptual impairments, motor disorders, and behaviors such as impulsiveness, low tolerance for frustration, and problems handling day-to-day social interaction and situations. These problems may mildly, moderately, or severely impair the learning process. Therefore, individuals with learning disabilities may exhibit a combination of characteristics.

Implications for Recreation

Some recreation professions report that the following strategies have been effective with some individuals who have learning disabilities:

- Capitalize on individual's strengths.
- Provide high structure and clear expectations.
- Use short sentences and simple vocabulary.
- Provide opportunities for success in a supportive atmosphere to help build self-esteem.
- Allow flexibility with project deadlines.
- Provide positive reinforcement of appropriate social skills and interaction.
- Recognize that children with learning disabilities can greatly benefit from the gift of time to grow and mature.

Seizures

Generalized Tonic-Clonic (Grand Mal)

What it looks like:

- Sudden cry, fall, rigidity, followed by muscle jerks, frothy saliva on lips, shallow breathing or temporarily suspended breathing, bluish skin, possible loss of bowel or bladder control, usually lasts 2-5 minutes. Normal breathing then starts again. There may be some confusion and/or fatigue, followed by a return to full consciousness.

Often mistaken for:

- Heart attack; stroke; unknown but life-threatening emergency.

What to do:

- Look for medical identification. Protect camper from nearby hazards. Loosen ties or shirt collars. Place folded jacket under head. Turn on side to keep airway clear. Reassure when consciousness returns. Use a soft voice when talking to them.

What not to do:

- Don't put any hard implement in their mouth. Don't try to hold the tongue-- it can't be swallowed (and you might get bit). Don't try to give liquids during or just after a seizure.
- Don't use oxygen unless there are signs of a heart attack. Don't use artificial respiration unless breaking is absent after muscle jerks subside, or unless water has been inhaled. Don't restrain.

Non-Convulsive Seizures:

Absence (Petit Mal)

What it looks like:

- A blank stare lasting only a few seconds. Most common in children. May be accompanied by rapid blinking, some chewing movements of the mouth. Camper is unaware of what is going on during the seizure, but quickly returns to full awareness once it has stopped. May result in learning difficulties if not recognized and treated.

Often mistaken for:

- Daydreaming; lack of attention; deliberate ignoring of instructions.

What to do:

- No first aid is necessary.

Simple Partial Seizure (Jacksonian)
What it looks likes:

- Jerking begins in fingers or toes, can't be stopped by the camper, but the camper stays awake and aware. Jerking may proceed to involve hand, then arm, and sometimes spreads to the whole body and becomes a convulsive seizure.

Often mistaken for:

- Acting out; bizarre behavior.

What to do:

- No first aid is necessary unless seizure becomes convulsive, then first aid as above.

Simple Partial (Sensory)
What it looks likes:

- May not be obvious to onlookers, other than the camper's preoccupied or blank. expression. Camper experiences a distorted environment. May see or hear things that aren't there, may feel unexplained fear, sadness, anger, or joy. May have nausea, experience off smells, and have a generally "funny" feeling in their stomach.

Often mistaken for:

- Hysteria; mental illness; psychosomatic illness; parapsychological or mystical experience.

What to do:

- No action needed other than reassurance and emotional support.

Complex Partial (Psychomotor or Temporal Lobe)
What it looks likes:

- Usually starts with a blank stare, followed by chewing, followed by random activity.
- Person appears unaware of surroundings, may seem dazed and may mumble.
- Unresponsive. May pick at clothing, pick up objects, try to take clothes off. May run and appear afraid. May struggles and flail at restraint. Once a pattern is established, the same set of actions usually occur with each seizure. Lasts a few minutes, but post-seizure confusion can last substantially longer. No memory of what happened during the seizure.

Often mistaken for:

- Drunkenness; intoxication on drugs; mental illness; indecent exposure; disorderly conduct; shoplifting.

What to do:

- Speak calmly and reassuringly to the camper and others. Guide gently away from obvious hazards. Stay with the camper until completely aware of the environment.

What not to do:

- Don't grab hold of the camper unless sudden danger threatens. Don't try to restrain.
- Don't shout. Don't expect verbal instructions to be obeyed.

Atonic Seizures (Drop Attacks)

What it looks likes:

- The camper suddenly collapses under them and they fall. After 10 seconds to a minute they recover, regain consciousness, and can stand and walk again.

Often mistaken for:

- Clumsiness; lack of good walking skills; normal childhood "stage."

What to do:

- No first aid needed unless injured during the fall.

Myotonic Seizures

What it looks like:

- Sudden, brief, massive muscle jerks that may involve the whole body or parts of the body. May cause a person to spill what they were holding or fall off of a chair.

Often mistaken for:

- Clumsiness; poor coordination.

What to do:

- No first aid needed, unless injured during a fall.

Grief and Loss

Grief is a different and personal experience for everyone, and we recognize the diversity of our community's coping styles and accept them. Camp Promise has resources available to support the emotional needs of our camp family, and we want you to know you are not alone in this.

Due to the nature of our work, we are at times confronted with how best to notify our community of the sad news of a camper's death. We must respect the wishes of families dealing with their loss, and balance it with how to best communicate this news with those who worked closely with the camper at camp.

In the case of a camper death and ONLY if we have permission from the camper's family, we will share the news (via email or phone call) to those people who directly worked with the camper within the last 12 months. The notified people will include:

- 1:1 counselors who worked with the camper
- Cabin counselors and Unit Leaders in the camper's cabin
- Camp medical team
- Program staff assigned to the camper's cabin

We also want to respect your own wishes in regard to what information you receive. If you would like to opt out of receiving this type of news, please let us know.

Remember, it's okay to...

Say I don't know.

Ask for more clarity.

Say you don't understand.

Ask what acronyms stand for.

Forget things.

Introduce yourself.

Depend on the team.

Ask for help.

Not know everything.

Have quiet days.

Have loud days, to talk, joke and laugh.

Make mistakes.

Sing.

Sigh.

Offer feedback on other's work.

Ask for feedback.

Not check your email for a day (or a week).

Challenge things you're not comfortable with.

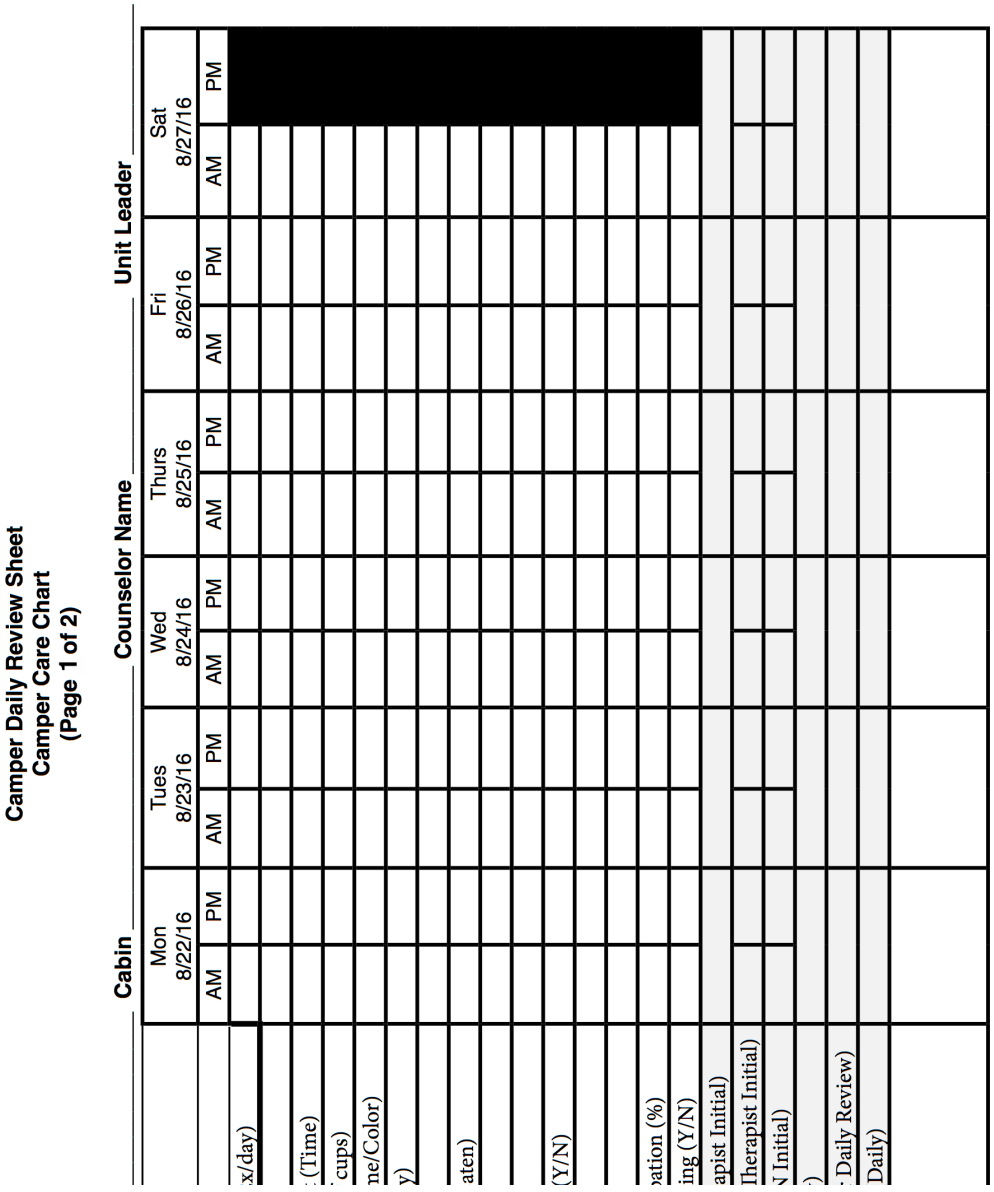
Snack.

Ask the leadership team to fix it.

Have an off-day.

Have a day off. (Once camp is over.)

Appendix 1: Camper Care Chart



Camper Daily Review Sheet
Camper Care Chart
(Page 1 of 2)

Cabin _____ **Counselor Name** _____ **Unit Leader** _____

	Mon 8/22/16		Tues 8/23/16		Wed 8/24/16		Thurs 8/25/16		Fri 8/26/16		Sat 8/27/16	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
x/day)												
(Time)												
cups)												
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ation (%)												
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apist Initial)												
Therapist Initial)												
Initial)												
)												
Daily Review)												
Daily)												

Camper Care Chart
Daily Review
(Page 2 of 2)

Camper Information
Camper Name _____ Cabin Color_____
Counselor Name_____

Please write a quick update on your camper's day. Remember to include things like participation (e.g., was in the play but didn't want to speak), general mood, interest in their day, behavior, any progression or improvement, and how they got along with other campers. Please also make a note of any problems, illnesses, or behavioral issues your camper may have had.

Monday, Aug 22: _____
_____
_____
_____

Tuesday, Aug 23: _____
_____
_____
_____

Wednesday, Aug 24: _____
_____
_____
_____

Thursday, Aug 25: _____
_____
_____
_____

Friday, Aug 26: _____
_____
_____
_____

Saturday, Aug 27: _____
_____
_____

Appendix 2: Accident/Incident Report

Camp Promise Accident/Incident Form
(Page 1 of 2)

This form is to be completed by any volunteers or staff involved in an accident or incident while at Camp Promise, whether they are witnesses or are involved themselves. Please complete this form as close to the incident as possible, while the details are fresh in your memory. A separate form should be completed by each person involved in the accident/incident.

Report Date (mm/dd/yyyy) _____ Report Time _____ ❑am ❑pm
Report completed by _____ Phone Number _____

Persons Involved
Name of primary person involved _____ ❑Camper ❑Volunteer ❑Staff ❑Visitor
Age _____ Gender _____ Cabin _____ Phone _____

Other participants involved or who witnessed the incident:
Name _____ ❑Camper ❑Volunteer ❑Staff ❑Visitor
Name _____ ❑Camper ❑Volunteer ❑Staff ❑Visitor
Name _____ ❑Camper ❑Volunteer ❑Staff ❑Visitor
Name _____ ❑Camper ❑Volunteer ❑Staff ❑Visitor
Name _____ ❑Camper ❑Volunteer ❑Staff ❑Visitor

Incident Details
Incident Date (mm/dd/yyyy) _____ Incident Time _____ ❑am ❑pm
Type of Incident: ❑Behavioral ❑Accident/Injury ❑Illness ❑Other (explain) _____
_____
Location of incident: _____
_____

Describe what happened (please be as detailed as possible, stating only facts; use additional pages as needed): _____
_____
_____
_____
_____
_____
_____
_____
_____

Action taken by counselors/staff: _____
_____

Is the injury apparent? ❑Yes ❑No If yes, please describe: _____
_____

What could have been done to prevent this incident? _____
_____

Signature _____ Date_____

Camp Promise Accident/Incident Form
(Page 2 of 2)

RN Report
This section is to be completed by the Camp Nurse.

Date of care (mm/dd/yyyy)_____ Time of Care _____ ❑am ❑pm
Extent of injury ❑Serious ❑Non-serious

Description of Injury _____
_____
_____
_____
_____
Treatment Provided _____
_____
_____
_____
_____

RN Report Completed By _____ Phone number _____
Signature _____ Date(mm/dd/yyyy) _____

Parent/Guardian/Emergency Contact Notification
Was the Parent/Guardian/Emergency Contact Notified? ❑Yes ❑No

Person Called _____ Relationship to Camper _____
Phone Number Called _____ Date of Call _____ Time of Call _____ ❑am ❑pm
Description of conversation (or voicemail left), including who called, who they spoke with, and conversation details _____
_____
_____

Person Called _____ Relationship to Camper _____
Phone Number Called _____ Date of Call _____ Time of Call _____ ❑am ❑pm
Description of conversation (or voicemail left) _____
_____
_____
_____

Person Called _____ Relationship to Camper _____
Phone Number Called _____ Date of Call _____ Time of Call _____ ❑am ❑pm
Description of conversation (or voicemail left) _____
_____
_____
_____

Notification Section Completed By _____ Phone number _____
Signature _____ Date(mm/dd/yyyy) _____

Appendix 3: Emergency Procedures (Camp Promise)

Fire

Fire drills will be rehearsed and practiced during Orientation and once during each session. Fire drill procedures will be reviewed with campers on the first day of camp at dinner.

All buildings are equipped with fire extinguishers and fire alarms with explicit instructions for their use. Each staff member is required to know their location and how they operate them.

There are two types of extinguishers:

- Dry chemical or CO2 extinguishers are designed for use on flammable liquid and electrical fires.
- Water extinguishers can be used for almost any other fire.

In Case of A Fire

- Core Buildings:
    - Pull the nearest fire alarm if not already sounding. This will automatically notify the 911 Dispatcher.
- Other Areas:
    - Shout and relay location of fire, for example, “Fire in Archery Area”.
- Administrative Staff will, if possible, announce the location of the fire over the PA system.
- A fire alarm panel (in the Main Entrance) will indicate the general location of a fire in the Core Building. Flashing lights on the outside of the building will also indicate where a fire is.

- Immediate action may be needed to save lives. **Life safety comes first!**
- Remove all campers from the immediate area of the fire.
    1. It is important to keep all corridors and exit doors clear for evacuees.
    2. Check all rooms, bathrooms, closest, and hallways for people while evacuating. It is important that every area in the location of the fire is thoroughly checked, as long as it is safe.
    3. Use the nearest exit, but remember there are many doors to exit through.
    4. When exiting the building any doors that can be shut should be shut.
    5. Everyone must report to the **flag pole** or **athletic field** immediately upon sounding of alarm and remain there until told otherwise. **Do not return to the building until explicitly told to do so. The alarm being turned off does not mean it is ok to return.**

- Unit Leaders are responsible for taking attendance and must report which of their campers and staff are unaccounted for. Administrative Staff will come to both locations to verify attendance.
- Unit Leaders and Counselors are to remain with their campers. Prevent panic by remaining calm, reassuring and under control.
- Administrative staff and facility staff should report to the scene of the fire as long as it is safe:
    1. Bring extra fire extinguishers and fire fighting equipment.
    2. Close windows and doors and shut off fans and lights.
    3. The Maintenance Coordinator or the Camp Directors will determine whether electrical power needs to be turned off.

If there is a fire at night **anywhere on property,** wake up the nurse and Camp Directors immediately.

If there is a fire in the Main Building at night, **one person on Night Duty** should go to the Cabins to wake up all sleeping staff members to report immediately to help.

Hurricane and Tornado Procedures

When word is received of an approaching hurricane or tornado, the Camp Directors will appoint staff to listen to the radio and/or television for advance warning and to monitor events throughout the storm.

- A hurricane warning means that a hurricane may hit within the next 36 hours.
- A watch is more imminent and means that a hurricane could hit a specific area within 24 hours.

If a hurricane or tornado is imminent, the Camp Directors (or in his/her absence, Assistant Director), will notify all campers and staff.

Campers and staff are to immediately proceed to the Dining Hall.

- If you cannot make it to the Dining Hall safely, or if a storm has begun, stay under cover until high winds/lightning subside.
- When sheltering a building, you should sit in the middle of the room, away from the walls, which lightning can travel through, and away from windows, which can break under high pressure.
- Areas on camp have been hit by lightning over the last few years, so it is important to make sure everyone on camp follow the safety rules.
- Urgency should particularly be taken by those at the swimming pool who will be directed to exit the pool and get changed immediately.

Cabin Leaders and counselors are to remain with their campers. Prevent panic by being calm, assuring, and under control.

Unit Leaders are responsible for taking attendance and must report which of their campers and staff are unaccounted for. Administrative Staff will come to both locations to verify attendance.

Administrative, Program and Logistics staff are to report to the Camp Directors to carry out the following tasks:

- Close windows and doors in all buildings.
- Close drapes, pulling shades and/or hanging blankets over windows.
- Secure or remove articles which might blow around.
- Fill all available containers with water (sinks, basins, etc.)
- The Maintenance Coordinator or the facility's Camp Directors will determine whether the electrical power needs to be turned off.

The Camp Nurse will have First Aid supplies and medications available.

Kitchen staff will be responsible for providing food.

Missing Camper

It is the responsibility of each individual counselor and Unit Leader to know the whereabouts of their assigned campers **at all times**. When a staff member leaves for a designated break, it is their responsibility to inform their Unit Leader and/or Float Counselor covering for them, where their assigned camper is located.

If you have any doubt about the whereabouts of a camper, DO NOT WAIT TO CALL FOR HELP!

If someone is identified as missing:

- Determine when and where the camper was last seen. Stay calm so you don't frighten the other campers.
- Discover (if possible) the state of mind of the camper. Was she depressed or angry, threatening to run away? Did he fall behind on a hike, or leave to visit a friend in another unit? A camper who does not wish to be found will require a wider and more careful search.
- Do a search of the immediate area with available staff. Ask nearby campers and staff if they have seen or know where the camper is. Before leaving the rest of the group to find a camper, see that they are supervised by another staff member.
    - Check any known accomplices (friends in other cabins, etc).
    - Check bathrooms, dining hall, the cabin, and friends' cabins.
    - Use walkie to see if other groups have a visual on the camper
        1. Be specific! "Does anyone have eyes on Johnny L from the Wolves? He was last seen in Lenny's Place wearing a red shirt and a baseball hat."

2. Never say a camper is missing over the walkie talkie

- If unfound, report the missing person(s) to the Camp Directors, or in his/her absence, the Assistant Director. Include the name of the missing camper, when and where last seen, description of camper: hair, eyes, weight, height, and, as close as possible, clothing.
- The Camp Directors and administrators will organize an extended search. The search will generally proceed as following:
    - The search will start in the middle of camp and spread outward.
        1. The camper's counselor and Unit Leader will do a search of common camper gathering areas.
        2. Staff will be assigned to search the following:
        3. The paved paths and roads within camp
        4. All buildings and program areas
        5. The wooded areas of camp
        6. One administrator will drive the roads.
    - Staff should immediately return to the Dining Hall when their assignment is finished to report back and be reassigned. Staff are not to set out on their own during the search operation.
- Do not ignore remaining campers. An appropriate number of staff will remain behind to supervise campers. The rest of camp should continue with activities as normal.
- The Camp Directors will determine whether the police or other emergency services will need to be contacted.
- The Camp Directors will determine whether, and if so, at what time the parents should be contacted.
- If the incident draws media attention, all inquiries are to be directed to the Camp Directors.
- Once found, the camper will be brought to the nurse for a thorough screening to determine the camper's health and well-being.
- The end of the search will be announced over the camp radios using the "all clear" signal.
- Complete incident report and any other reports requested.

Intruder/Lockdown

Unfamiliar persons on the camp property may range from someone lost and looking for directions to a person with intent to do harm to persons or property. Some judgment must be made on the part of staff. Be observant as to the make, model, and license number of the car. Persons should be questioned to ascertain who they are and why they are here. Do not antagonize the intruder. Be polite, give assistance if possible, refer the person to the camp office, or ask them to leave. This is private property and not open to the public. Observe to ascertain that the person leaves the site.

If the appearance of the unfamiliar person makes you uncomfortable, approach with another staff member. Someone should stay with the campers away from the situation. If the person seems threatening in any way, do not approach or take any chances. Remove yourselves and the campers from the area, notify the camp office, and observe the whereabouts of the person.

If you see or suspect an intruder in camp at night, immediately and quietly notify the other staff members and the Camp Directors. Check all camper sleeping areas with a head count. In order to prevent false alarms and unnecessary fright, all camp personnel will carry flashlights and identify themselves when walking in the camp at night.

Lock-Down Procedures

- Lockdown will be initiated in response to the following:
    - An intruder with a visible weapon
    - An intruder with suspicious clothing, for concealing a weapon or bomb
    - Any kind of nuclear, chemical, or airborne pathogen of any kind.
- If a staff person sees someone on the property with a weapon or if a staff person hears a gun shot:
    - Announce the sighting/sound over the radio and move into lockdown mode.
    - An administrator will call for a lockdown over the radio, if possible, if it has not yet been done.
- Indoors:
    - Staff should scan the hallways or program area and bring in as many campers as possible from the hallways as quickly as possible.
    - Staff should close and lock the doors to the room, and barricade the doors.
    - Staff are to have campers gather in the safest area of the room, away from doors and windows.
    - Staff can decide to evacuate and leave the property.
    - When it is safe, an administrator or police officer will unlock the door.
- Outdoors:
    - If possible and safe to do so, staff are to move campers off the property as quickly as possible.
    - Call 911 once you have moved to that area to let the first responders know where you are.
- Unit Leaders are responsible for taking attendance wherever they are and should notify the administrative staff of any campers or staff who are unaccounted for as soon as possible via radio.
- **Simultaneously**: The Camp Directors will activate emergency services. This would include any pertinent details, as available. This same person would be the ONLY ONE authorized to issue the all clear.

Appendix 4:

Requirements to attend-Covid 19 Policy & Procedures 2023

Please note that this policy is subject to change, as the climate around the current pandemic evolves, we reserve the right to make revisions to this policy. Any revisions made to the policy will have to be signed again by the camp participant or guardian of.

1. **Camp Attendance**
    - In order to attend camp all campers, volunteers, & staff **must:**
        i. Agree to comply with ALL policies and protocols.
2. **Vaccine**
    - As recommended by current CDC guidelines for immunocompromised individuals: All participants must provide proof of full Covid 19 vaccine, along with the most current Covid 19 booster shot available as of **May 1, 2023**.
3. **Camp Arrival Checks**
    - Everyone arriving at camp will have a symptom assessment (temp check, etc.) in addition to a general health screen.
    - A Covid-19 antigen test will be administered at no cost to all participants upon arrival to camp. (Camp Promise will provide these tests)
4. **Cleaning & Sanitizing**
    - Cleaning protocol training with all be conducted with staff & volunteers
    - All high-use areas (sleeping facilities, restrooms) will be sanitized on a regular basis.
    - Handwashing and sanitation stations will be located throughout camp.

Additional Precautions:

1. Face coverings, (masks or shields) will be optional for all participants.

2. We will host as many activities in outdoor/well ventilated spaces as possible. (including dining)

Should someone exhibit symptoms, not feel well, and/or test positive for Covid 19:

1. We will immediately separate staff and/or campers with symptoms. (fever, cough, or runny nose)
2. Individual(s) will be placed in a designated isolation area.
3. A dedicated medical team member will utilize Standard and Transmission-Based Precautions in treating individual(s).
4. A Covid 19 Rapid Antigen test will be administered.
5. We will alert the camp facility and follow all protocols specific to that facility.
6. We will call parents/emergency contacts.
7. We will help to finalize a plan of action for transport from camp to home/PCP or hospital/emergency room if necessary, based on severity of symptoms, or if the individual tests positive for Covid.

Close Contacts:

1. All staff/campers deemed to be in close contact with a person with symptoms, will also be quarantined and tested for Covid, via Rapid Antigen test.
2. Camp Directors will contact parents/emergency contacts immediately to notify them if the camper/volunteer has been exposed to an individual who has tested positive for Covid 19.

Noncompliance with this policy may result in expulsion from camp.