



Chornomorska Sitch Sports School

60-C North Jefferson Rd.
Whippany, NJ 07981

Dear Parents & Sitch Sports School Campers,

We are pleased to announce that Sitch will be at VOVCHA TROPA for our third year this summer for the 54th annual Sports School - subject to Columbia County Health Department approval and in accordance to any guidelines set by the Health Commissioner. We are excited about continuing at a location that is known for its sprawling 350 acres of beautiful rolling hills, fields and forests. We believe that Vovcha Tropa, with its facilities, sports fields and swimming pools, is the perfect place for Sitch camp.

REGISTRATION

Completed registration paperwork, including online and medical forms, as well as full payment of camp tuition is due no later than June 15, 2025. Failure to meet this deadline may result in your camper losing his/her spot at camp. Payment may be sent via PayPal link online or by check. (Checks made payable to Chornomorska Sitch and mailed to c/o Chornomorska Sitch Sports School, UACCNJ, 60-C North Jefferson Rd., Whippany, NJ 07981)

Total Cost is **\$900 per camper** (includes overnight accommodations and 24-hr supervision; 3 meals per day, access to facilities and camp instruction; t-shirt included)

Once registration, paperwork and payment are received, you will receive a confirmation email advising you of additional information concerning drop off, etc.

HEALTH & SAFETY PROTOCOLS

The safety of our campers and staff are of utmost importance. We continue to work closely with Vovcha Tropa Management and the Health Department to ensure that our program is compliant with all necessary safety protocols and regulations.

Please be advised that our plans and protocols are subject to change as we await final permits and guidance from the Health Commissioner. We will keep you apprised of any changes or additional requirements as the summer nears.

As always, thank you for your continued support of Chornomorska Sitch Sports. We look forward to another fun-filled and safe experience this summer.

Thank you.



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Dear Parent,

Enclosed please find the following medical forms that are due by **June 15, 2025**. Each of these forms needs to be completed for every camper. Please send all forms together at the same time.

1. **Camper Health History:** Part 1 to be filled out by parent, Parts 2 and 3 to be filled out by licensed clinician. Camper Over-the-Counter Medication form must be filled out by clinician to allow over-the-counter medications to be administered at camp.
2. **Meningitis Form:** to be filled out by parent.

In addition, please enclose with these forms:

3. **Copy of insurance card** (front and back) or copy of "No Insurance Form"
4. **Copy of camper vaccine records.** The immunization record must include the immunization dates and is necessary for your child to attend camp. A notation that immunizations are "up to date" is not acceptable.

Forms can be returned to Nicholas Prociuk at Nicholas_Prociuk@SHI.com

Any questions regarding forms can be directed to Nicholas Prociuk, Camp Administration.

If your child has a medical concern that you would like to discuss prior to the start of camp, please email us to set up a time. Please note that **all medications for your child must be in their original containers, and properly labeled.** Prescription medications must have complete name of patient, date filled, expiration date, directions for use, name and address of dispensing pharmacy, and name of physician prescribing medication. When over-the-counter medications are provided for the child, then instructions for use (i.e. from the parent or physician) must accompany said medication.



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Camper Health History

Section 1. Camper Information *(completed by parent)*

Name (Last, First) _____ DOB _____ Sex _____ Age _____

Parent(s) or Guardian(s) _____

Home Address _____

Parent(s)/Guardian(s) _____

Parent (#1) Email Address _____ Parent Phone Number _____

Parent (#2) Email Address _____ Parent Phone Number _____

Health Insurance Name _____

Health Insurance Policy Number _____

Name of Camper's Doctor _____

Phone Number of Camper's Doctor _____

Name of Camper's Dentist/Orthodontist _____

Phone Number of Camper's Dentist/Orthodontist _____

Camper Dietary Restrictions _____

Camper Allergies _____

Does Camper Require an Epi-Pen? ☐ Yes ☐ No

Is camper coming to camp with any daily medications? ☐ Yes ☐ No

Parent Attestation

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel at Sitch camp to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel at Sitch to act for me, and to obtain for my child whatever medical treatment the medical personnel in its best judgement deems necessary and appropriate for the care and treatment of my child, including but not limited to whatever medical, surgical, or dental examination, diagnosis and/or treatment is deemed necessary.

Parent Signature _____ Date _____



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Section 2. Camper Health History (completed by licensed clinician, part 1 of 3)

Please be advised that this form is for a 10-day overnight camp.

**** Please append a *complete vaccination record* and any *special care plans* (for example, asthma or seizure action plans) to this record****

Name (Last, First) _____ DOB _____

Date of Physical Examination _____ Results of Physical Exam Normal? _____

Weight _____ Height _____ For female patients, LMP: _____

Chronic Medical Conditions _____

Past Surgeries _____

Medications/Treatments _____

Allergies/Sensitivities _____

Does this camper require an Epi-Pen? ☐ Yes ☐ No

Special Diet Requirement _____

Behavioral Issues/Mental Health Diagnoses _____

Emergency Plans Attached _____

Licensed Clinician Signature _____

Licensed Clinician Name _____

Date of Completion _____ Office Phone Number _____



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Camper Name (Last, First) _____ DOB _____

Section 3. PRN Over the Counter Medications *(completed by licensed clinician, part 2 of 3)*

Clinician, please check off medications which you **ALLOW** the patient to receive on as needed basis while attending camp. The following medications will be administered as first aid as directed on packaging, based on child's weight and age, at the discretion of the clinician on duty. If authorizing OTC medication that is NOT listed below, please indicate details in the prescribed medication section.

Drug Name	Camper May Receive	Drug Name	Camper May Receive
Acetaminophen (Tylenol)		Hydrocortisone 1% (Steroid Cream)	
Aloe/burn gel		Ibuprofen (Advil, Motrin)	
Antacid		Lice Shampoo	
Antibiotic Ointment (Bacitracin)		Loperamide (Imodium)	
Bismuth Subsalicylate (Pepto Bismol)		Loratadine (Claritin)	
Calamine Lotion		Midol	
Calcium Carbonate (Tums)		Nasal Saline Spray	
Cetirizine (Zyrtec)		Polyethylene Glycol (Miralax)	
Dextromethorphan (Cough Medication)		Pseudoephedrine (Sudafed)	
Diphenhydramine (Benadryl)		Simethicone (Gas Relief)	
Ear Drying Drops		Stool Softener	
Eye Drops (Lubricating)		Throat lozenge	
Eye Irritation Drops (Visine)		Topical Antifungal	
Fexofenadine (Allegra)		Topical Antihistamine Cream/Gel (Anti-itch)	

Section 4. Prescribed Medications *(completed by licensed clinician, part 3 of 3)*

Drug Name	Dose	Route	Indication

Patient Allergy and Reaction to Prescription Medication _____

Licensed Clinician Signature _____

Licensed Clinician Name _____

Date of Completion _____ Office Phone Number _____



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Meningococcal Meningitis Vaccination

Dear Parent:

We write to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Health Law (NYS PHL) §2167 and Subpart 7-2 of the State Sanitary Code requires overnight children's camps to distribute information about meningococcal disease and vaccination to all campers who attend camp for 7 or more consecutive nights.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illness such as infection of the lining of the brain and spinal cord (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, and limb amputation, in as many as one in five of those infected. Ten to 15 percent of those who get meningococcal disease will die.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that cause meningococcal disease even before they know they are sick.

Anyone can get meningococcal disease, but certain people are at increased risk including teens and young adults 16 – 23 years old and those with certain medical conditions that affect the immune system.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause meningococcal disease in the United States. The Centers for Disease Control and Prevention (CDC) recommends a single dose of MenACWY vaccine at age 11 through 12 years with a booster dose given at age 16 years. Children are not routinely recommended to receive MenACWY vaccine prior to the recommended ages, unless they have certain underlying medical conditions which increase their risk of disease. The meningococcal B (MenB) vaccine protects against a fifth strain of meningococcal bacteria which causes meningococcal disease. Young adults aged 16 through 23 years may be vaccinated with MenB vaccine and should discuss the MenB vaccine with a healthcare provider.

I encourage you to carefully review the attached Meningococcal Disease Fact Sheet. It is also available on the New York State Department of Health website at: <http://www.health.ny.gov/publications/2168.pdf>.

Information about the availability and cost of meningococcal vaccine can be obtained from your healthcare provider or your local health department.

Sitch is required to maintain a record for each camper, signed by the camper's parent or guardian, which documents the following:

- Receipt and review of meningococcal disease and vaccine information; AND EITHER
- Certification that the camper has been immunized against meningococcal meningitis within the past 10 years; OR
- An understanding of meningococcal disease risks and benefits of vaccination at the recommended ages and the decision not to obtain immunization against meningococcal meningitis at this time.

Please complete the enclosed Meningococcal Meningitis Vaccination Response Form and return it with your other health records.

To learn more about meningococcal meningitis and the vaccine, please consult your child's physician. You can also find information about the disease at the website of the Centers for Disease Control and Prevention:

www.cdc.gov/vaccines/vpd-vac/mening/default.htm.

Sincerely,

Chornomorska Sitch Sports School



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Camper Name (Last, First) _____ DOB _____

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

The Centers for Disease Control and Prevention recommends two doses of MenACWY vaccine (Brand names: Menactra, Menveo) for all healthy adolescents 11 through 18 years of age: the first dose is given at 11 or 12 years of age, with a booster dose at 16 years of age. Children and adolescents with certain medical conditions may need to begin the MenACWY series at a younger age and/or receive additional doses. Consult with your child's healthcare provider regarding any medical conditions they may have.

If the first dose is given between 13 and 15 years of age, the booster should be given between 16 and 18 years of age. If the first dose is given after the 16th birthday, a booster is not needed.

Young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series (Brand names: Trumenba, Bexsero). Parents/guardians should discuss the Meningococcal B vaccine with a healthcare provider.

Please check one of the following:

☐ My child is 10 years old or younger and is not eligible for the meningococcal vaccine. I have read, or have had explained to me, the information regarding meningococcal meningitis disease and I understand the risks.

☐ My child has received the meningococcal conjugate vaccine (MCV4, brand names Menactra or Menveo)

Dose 1 Date Received: _____

Dose 2 Date Received: _____

☐ My child is 11 years old or older and I have decided that my child will **not** obtain immunization against meningococcal meningitis. I have read, or have had explained to me, the information regarding meningococcal meningitis disease and I understand the risks of not receiving the vaccine.

Parent Signature _____ Date _____



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No Insurance Form

This form only needs to be completed if your child does NOT have health insurance

April 2025

Dear Parent/Guardian:

It is Chornomorska Sitch Sports School Policy that parents/guardians are responsible for payment of all healthcare services received by their child(ren) during their stay at Sitch Camp – Vovcha Tropa. Because you have no health insurance coverage for your child(ren), you are personally responsible for paying all health care charges and fees incurred by your child(ren) while at Sitch Camp – Vovcha Tropa.

Name of Child(ren) Attending Camp _____

Date Child(ren) Attending Camp _____

I have read and understand the above policy and hereby accept responsibility for payment for any health care services provided to my child(ren) while at Sitch Camp – Vovcha Tropa.

I understand that Sitch Camp – Vovcha Tropa will not be responsible for compensating the parent or guardian for tuition fees lost due to any injury, medical issues, illness or damage sustained to my child from any cause whatsoever, including negligence or carelessness resulting directly or indirectly that the above named child may experience while participating in Sitch camp.

Parent Signature _____

Date _____

**IF YOUR CHILD HAS NO MEDICAL INSURANCE, HE/SHE CANNOT PARTICIPATE IN CAMP
WITHOUT THIS COMPLETED FORM**