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Description automatically generated with medium confidence**

**Camp Re-Entry Report**

Directions for Use: When staff or campers have to leave camp for issues of well-being, we ask that this re-entry form be completed prior to staff or camper return to the camp experience. This information provides guidance to support the individual upon return. For some situations, a healthcare provider will need to sign the form to allow re-admittance to camp for the safety and wellbeing of everyone involved.

Please complete the form in its entirety and send to the camp prior to returning to camp. This allows time for review and questions of clarification if needed.

**Re-Entry Individual** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Camp Departure**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_ am/pm

Day of week Month Day Year

**Date of Camp Return**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_ am/pm

Day of week Month Day Year

Camper  Staff  Volunteer Age:\_\_\_\_\_\_\_\_\_\_\_  Male  Female

How long has individual been away from camp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days

Reason for Departure:  Behavioral  Injury  Homesickness  Harm to Self  Illness

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Departure Details (ex: had fever, care needed outside scope of camp care; concern for safety of others)

Update/Improvements since departure:

What interventions were provided to address individual concern/issue?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is additional care or follow up needed while at camp? (Please describe if so)

Signature by (adult staff or parents)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare (HCP) provider signature (as appropriate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HCP phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Camp Director signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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