Camper Health Form Part I & II (Parents)
Part III (Physician)

Part I

Camper Name:_____ Birthdate: _____ Sex: M - F Age:____

Last Name First Name MM/DD/YYYY Circle one

Parent/Guardian Name: _____ Email Address:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____

Home Address:_____

Street & Number City State or country Zip Code

If not available in an emergency notify:

Name:_____Relationship to Camper_____ Phone: (_____)_____

Address:_____

Street & Number City State or country Zip Code

HEALTH HISTORY: If you answer yes please give detail in the space below.

Ever been hospitalized?	Y___ N___	Had mononucleosis ("mono") during the past 12 months?	Y___ N___
Ever had surgery?	Y___ N___	Had/have asthma/wheezing/shortness of breath?	Y___ N___
Have recurrent/chronic illness?	Y___ N___	Wear glasses, contacts or protective eyewear?	Y___ N___
Have recurrent infectious disease?	Y___ N___	Have problems falling asleep/sleepwalking?	Y___ N___
Had a recent injury?	Y___ N___	Ever had back or joint problems?	Y___ N___
Have diabetes?	Y___ N___	Have a history of bedwetting?	Y___ N___
Had/have seizures?	Y___ N___	Have problems with diarrhea/constipation?	Y___ N___
Had fainting or dizziness?	Y___ N___	Have any skin problems?	Y___ N___
Have headaches?	Y___ N___	Have any ear infections/swimmers ear?	Y___ N___
Passed out/had chest pain during exercise?	Y___ N___	Traveled outside the Unite States in the past 9 months?	Y___ N___

Please explain "Yes" answers below:

If yes please list the countries_____

Allergies

☐ NO Known Allergies

☐ This camper is allergic to - Food____ Medicine____ Environment (insects, plants, seasonal)____ Other____

If Allergic please give specific allergy, reaction, and action plan and medication.

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Camper Health Form Part II

Medications

☐ Camper will not take any daily medications while attending camp.
☐ Camper will take the following daily medication while at camp:

Medication	Reason for Taking	When to be given BK/Lunch/Dinner/Bed/Other	Dosage

Restrictions

☐ I have reviewed the program and activities and feel my camper can participate in all activities without restrictions.
☐ I have reviewed the program and activities and feel my camper can participate with the following restriction:

Diet

☐ Camper eats a regular diet
☐ Camper has a special food needs *(Please Describe)*

Mental, Emotional and Social Health

Ever been treated for attention deficit disorder(ADD) or attention deficit/hyperactivity disorder(AD/HD)? Y____ N____
Ever been treated for emotional or behavioral difficulties or eating disorder? Y____ N____
During the past 12 months have you seen a professional to address mental/emotional health concerns? Y____ N____
Had a significant life event that continues to effect the camper's life Y____ N____
Please explain "Yes" answers below:

Any additional information about your camper or their health that you think important to share with the camp staff for the success of your camper in the program?

Health Insurance Information

Insurance Company Name_____ Policy Number_____
Name of Insured_____ Relationship to camper_____
Insurance Company Phone Number_(____)_____

Parental Authorization

The health history, health examination, and insurance information are correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. I also give permission for this person to participate in wilderness swimming which will be taking place in the Western Adirondack State Park during hiking and/or boating trips in remote areas that are not readily accessible for inspection to the local health department. The wilderness swimming areas selected will be inspected by camp staff for safety in regards to clarity, depth and current. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named. I understand the information on this form will be shared on a need to know basis with camp staff. The camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the staff about my child's health status.

Parent/Guardian Signature_____Date_____

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Camper Health Form Part III

Over the Counter Medications

For your camper's future medical needs at Woodcraft the NYS Department of Health requires direction from your family doctor for us to administer any over the counter medications on an as needed basis. Below is a list of commonly used drugs for your doctor's approval. If there are any additional drugs your doctor thinks are appropriate please include them at the end.

To be completed by camper's Licensed Physician	Physician's Approval	
	YES	NO
Swimmer's Ear: Isopropyl Alcohol 1-2 drops every 4 hours		
After Bite or Diphenhydramine HCL 2% for insect bites/itch relief		
Bug Repellent: to prevent bug bites		
Alcohol wipes: for cleaning small wounds		
Betadine: for cleaning small wounds		
Hydrogen Peroxide: for cleaning small wounds		
Sun block: prevention of sun burn		
Moisturizing lip treatment/sun block: prevention		
Antifungal cream: for athlete's foot or for fungal infections		
Ibuprofen: per child's weight/age given every 4-6 hours (*pain, swelling, fever)*		
Acetaminophen: per child's weight/age given every 4-6 hours (*pain, swelling, fever)*		
Diphenhydramine: 25 mg every 4 hours *for minor allergies or minor allergic reaction*		
Hydrocortisone 1% cream: for local/topical skin irritation		
Pseudoephedrine over 12 yrs. age: for stuffy nose due to allergy		
Throat Lozenges: non-medicated, 1 every hour (as needed) for throat irritation		
Antibiotic ointment: for minor cuts/scrapes		
Petroleum Jelly: for minor skin irritations		
Aloe Cream/Cooling gel: for minor burns and sunburn		
Calamine Lotion: for bug bites or poison ivy		
Poison Ivy Cream: for itch and drying		
Lice Treatment Shampoo		
Saline eye wash: for minor eye irritation		
Cough Syrup: use as directed		
Please add any additional medication approved by a physician:		

Continues on next page with signature required

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Camper Health Form Part III - Continued

To be completed by camper's Licensed Physician

MEDICAL EXAMINATION

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is to determine fitness to engage in strenuous activity.

Code:
S = Satisfactory X = Not satisfactory (explain) O = Not Examined

Eyes	_____	Extremities	_____	General Appraisal:
Glasses	_____	Posture (spine)	_____	
Ears	_____	Skin	_____	
Nose	_____			
Throat	_____	Height	_____	
Teeth	_____	Weight	_____	
Heart	_____	Blood Pressure	_____	
Lungs	_____	Hgb. Test	_____	
Abdomen	_____	Urinalysis	_____	
Hernia	_____	Allergy (specify)	_____	

Do you feel the camper should have limitations or restrictions to any camp activities? Y_____ N_____
If you answered "Yes" please describe the suggested restrictions.

I have examined the person herein described and have reviewed his/her Camper Health Forms. It is my opinion that he/she is physically able to engage in camp activities, except as noted. I have also indicated which over the counter medications are allowable.

Physician's Name (Please Print) _____ **Date** _____

Signature _____ **Phone** _____

Physician's Address: _____

Physician email _____

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MENINGITIS VACCINATION INFORMATION

Spring 2018

Dear Parent:

I am writing 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 column (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.

Adirondack Woodcraft Camps 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 to Adirondack Woodcraft Camps along with the rest of your camper health forms.

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, Adirondack Woodcraft Camps

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MENINGITIS VACCINATION RESPONSE FORM

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.

Check one box and sign below.

- ☐ I have received and reviewed the information regarding meningococcal meningitis. My child has received meningococcal immunization (Menactra or Menveo) within the past 10 years.

  Date received:

  OR

  I have received and reviewed the information regarding meningococcal meningitis. I understand the risks of meningococcal meningitis and the benefits of immunization at the recommended ages.

- ☐ I have decided that my child, who is younger than 11 years of age, will not obtain immunization against meningococcal disease at this time; or

- ☐ I have decided that my child, who is 11 years of age or older, will not obtain immunization against meningococcal disease at this time.

Signed: _____ Date: _____
(Parent/Guardian)

Camper Name: _____ Date of Birth: _____

Mailing Address: _____

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