



Camper Health Form

Page 1,2,3 & 6 (Parents)

Page 3 & 4 (Physician)

Page 1

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 Insurance Information

Insurance Company Name _____ Policy Number _____

Name of Insured _____ Relationship to camper _____

Insurance Company Phone Number (____) _____

Parental Authorization - PERMISSION TO TREAT

The health history, health examination, and insurance information are correct as far as I know, and my child as named has permission to engage in all camp activities, except as noted by me and the examining physician. I also give permission for my child to participate in wilderness swimming which will be taking place in NY state and in 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 swim 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. I give permission for my child to carry and use any FDA approved over the counter sun screen for protection from the sun and to carry and use all insect repellants unless otherwise noted on my health form under Part III.

Parent/Guardian Signature _____ Date _____

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*)



Camper Health Form Page 2 _____

(Camper Name)

Medications

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

*All over the counter medications must be in the original packaging.

**All RX meds must be in the original bottle with, Pharmacy info, Prescribing Dr, Camper Name, Use instructions, Medication name and dose and the expiration date. Please send your child with adequate supply for their full stay.

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

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?

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.

HEALTH HISTORY: If you answer yes please give detail 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 United States in the past 9 months? Y___ N___

Please explain "Yes" answers below:

If yes please list the countries_____



Camper Health Form Page 3 Over the Counter Medications

_____ **(Camper Name)**

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 approval and doctor's final approval.

<i>To be completed by camper's Licensed Physician</i>	Parental Approval	
	YES	NO
Acetaminophen: per child's weight/age given every 4-6 hours (<i>pain, swelling, fever</i>)		
<i>After Bite</i> for insect bites/itch relief		
Alcohol wipes: for cleaning small wounds		
Aloe Cream/Cooling gel: for minor burns and sunburn		
Antibiotic ointment: for minor cuts/scrapes		
Antifungal cream: for athlete's foot or for fungal infections		
Benadryl: per child's weight/age		
Betadine/Iodine: for cleaning small wounds		
Bug/Insect Repellent: to prevent bug bites		
Diphenhydramine HCL 2% for insect bites/itch relief		
Calamine Lotion/Poison Ivy Cream: for bug bites or poison ivy		
Daytime Cold and Flu: use as directed		
Diphenhydramine: 25 mg every 4 hours <i>for minor allergies or minor allergic reaction</i>		
Cough Syrup (dextromethorphan): use as directed		
Gas-X (simethicone)		
Hydrocortisone 1% cream: for local/topical skin irritation		
Hydrogen Peroxide: for cleaning small wounds		
Ibuprofen: per child's weight/age given every 4-6 hours (<i>pain, swelling, fever</i>)		
Lice Treatment Shampoo		
Moisturizing lip treatment/sun block: prevention		
Petroleum Jelly: for minor skin irritations		
Poison Ivy Cream: for itch and drying		
Pseudoephedrine over 12 yrs. age: for stuffy nose due to allergy		
Saline eye wash: for minor eye irritation		
Sun block: prevention of sun burn		
Throat Lozenges: non-medicated, 1 every hour (as needed) for throat irritation		
Tums (Calcium Carbonate)		
Parents please list any specifications regarding certain brands to avoid. Or any other notes you have regarding use of over the counter medications for your child.		

Physician's Signature - Approving above parent list _____



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

Grid for medical examination with categories: Eyes, Glasses, Ears, Nose, Throat, Teeth, Heart, Lungs, Abdomen, Hernia, Extremities, Posture(Spine), Skin, Urinalysis, Allergy (Specify), Height, Weight, Blood Pressure, Hgb. Test, General appraisal.

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.

IMMUNIZATION HISTORY

Required immunization must be determined locally. This is a record of dates of basic immunizations and most recent booster doses. Attach a copy of immunization record if available.

Immunization record grid with categories: DDT Series, MMR, Tuberculin Test, Booster, Hepatitis B, Tetanus Booster, Polio, Hepatitis A, Influenza Type B, Booster, Pneumococcal, Varicella (Chicken Pox).

If your child is not immunized NY State requires that you list which vaccines you choose not to administer and provide your reasoning for this.

Parent Statement:

Parent Signature:

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



MENINGITIS VACCINATION INFORMATION

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



MENINGITIS VACCINATION RESPONSE FORM

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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: _____
(Parent/Guardian)

Date: _____

Camper Name: _____ Date of Birth: _____

Mailing Address: _____