Health History and Treatment Authorization Form

Vanderkamp Center _ 337 Martin Road _ Cleveland, NY 13042
315-675-3651 _ vkcenter@vk.org

Date of Program: _____

Please return by: _____

The information on this form is gathered to assist us in identifying appropriate care. The Health History and Treatment Authorization Form is to be completed by the parent/guardian of minor campers or by adult campers, and must be updated annually. A physical examination must be completed by licensed medical personnel at least every two years.

Camper's Name _____ **Gender:** __ **Male** __ **Female** **Age at camp** _____ **Birth Date** _____

Address _____
Street **City** **State** **Zip**

	Custodial parent / guardian	Second parent / guardian	If parent / guardian is not available in an emergency, contact:
Name			
Home phone	( )	( )	( )
Work phone	( )	( )	( )
Cell phone	( )	( )	( )

Is the camper covered by medical insurance? __ **Yes** __ **No**

If yes, indicate carrier or plan name _____ **Group #** _____

Please attach a copy of the front and back of your health insurance card to this form.

Name of family physician _____ **Phone** ( ) _____

Name of family dentist _____ **Phone** ( ) _____

Has/does the camper:	Yes	No
1. Had any recent injury, illness, or infectious disease?	___	___
2. Have a chronic or recurring illness / condition?	___	___
3. Ever been hospitalized?	___	___
4. Ever had surgery?	___	___
5. Have frequent headaches?	___	___
6. Ever had a head injury or been knocked unconscious?	___	___
7. Wear glasses, contacts, or protective eye wear?	___	___
8. Ever had frequent ear infections?	___	___
9. Ever passed out or been dizzy during or after exercise?	___	___
10. Ever had chest pain during or after exercise?	___	___
11. Ever had seizures?	___	___
12. Ever had high blood pressure?	___	___
13. Ever been diagnosed with a heart murmur?	___	___
14. Ever had back problems?	___	___

	Yes	No
15. Ever had problems with joints (e.g. knees, ankles)?	___	___
16. Have an orthodontic appliance being brought to camp?	___	___
17. Have skin problems (e.g. itching, rash, acne)?	___	___
18. Have diabetes?	___	___
19. Have asthma?	___	___
20. Had mononucleosis in the past 12 months?	___	___
21. Had issues with diarrhea/constipation?	___	___
22. Have a history of sleepwalking?	___	___
23. If female, have an abnormal menstrual history?	___	___
24. If female and she has not yet menstruated, has she been told about it?	___	___
25. Have a history of bed-wetting?	___	___
26. Have an eating disorder?	___	___
27. Had emotional difficulties for which professional help was sought?	___	___

Please explain any "Yes" answers, noting the number of the question. _____

_____

_____

_____

_____

ALLERGIES: List all known allergies to medications, foods, or other substances. Describe reaction and management of the reaction.

_____ _____

_____ _____

_____ _____

RESTRICTIONS: The following dietary / activity restrictions apply to this camper: _____

_____

ADDITIONAL INFORMATION about the camper's behavior or physical, emotional, or mental health of which the camp should be aware:

_____

_____

_____

IMMUNIZATION HISTORY:
Please give all dates of immunizations or attach immunization history.

Which of the following illnesses has the camper had?	Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
___ Measles	DTP	_____	_____	_____	_____	_____	_____
___ Chicken pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
___ German measles	Tetanus	_____	_____	_____	_____	_____	_____
___ Mumps	Polio	_____	_____	_____	_____	_____	
___ Hepatitis A	MMR	_____	_____				
___ Hepatitis B	or Measles	_____	_____				
___ Hepatitis C	or Mumps	_____	_____				
	or Rubella	_____	_____				
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____		
Date of last test _____	Hepatitis B	_____	_____	_____			
Result: _____	Varicella (Chicken pox)	_____	_____				
	Meningococcal meningitis	_____					

IMPORTANT - This section must be signed for attendance.

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person named herein has permission to engage in all camp activities, except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be needed, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission to the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person named herein is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I hereby agree to the disclosure to camp representatives of the protected health information of the person described herein, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named herein. This form may be photocopied for trips out of camp.

I understand that I will be contacted if my child is exposed to a communicable disease or if medical referral is necessary.

Signature of parent/guardian or adult camper/staff member X _____

Printed name _____ **Date** _____

I understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of camper / staff member _____ **Date** _____

Report of Physical Examination

Vanderkamp Center _ 337 Martin Road _ Cleveland, NY 13042
315-675-3651 _ vkcenter@vk.org

Date of Program: _____

Please return by: _____

Camper's Name: _____ Date of Birth: _____

A physical examination must be conducted by licensed medical personnel within two years of the end of the camper's stay at camp.

Date of exam: _____ BP _____ Weight _____ Height _____

This camper is under the care of a physician for the following conditions: _____

_____

_____

General appraisal: _____

_____

_____

Known allergies: _____

Restrictions / limitations to be followed at camp: _____

_____

Additional information about the camper's behavior or physical, emotional, or mental health of which the camp should be aware:

_____

_____

_____

_____

_____

_____

_____

_____

I have examined this person on the date shown above. In my opinion, he/she is able to participate in an active camp program, except as noted.

Signature of health care provider X _____ Date_____

Printed name _____ License # _____

Medication Administration Orders

Vanderkamp Center _ 337 Martin Road _ Cleveland, NY 13042
315-675-3651 _ vkcenter@vk.org

Date of Program: _____

Please return by: _____

Camper's Name _____ Birth Date _____

New York State requires written orders for dispensing any medications. This page must be signed by a physician or other licensed medical personnel and by the camper's parent/guardian.

STANDING ORDERS FOR OVER-THE-COUNTER MEDICATIONS: The following over-the-counter medications are available at camp. If marked "Yes," they may be dispensed to the person named above for the indicated conditions, according to label directions. In all cases, generic medications may be used in place of name brands.

YES	NO	
____	____	Acetaminophen - By mouth for headache, fever, menstrual cramps, or minor pain
____	____	Aloe Vera Gel - Topically for pain related to burns or sunburn
____	____	Bacitracin Antibiotic Ointment - Topically for minor cuts, scrapes, or burns
____	____	Benadryl - By mouth for sneezing, itching, hives, or rash, or swelling due to insect bites or stings
____	____	Cepacol Sore Throat Lozenges - By mouth for minor irritation, pain, sore mouth, or sore throat
____	____	Calamine Lotion - Topical for skin irritation

YES	NO	
____	____	Hydrocortisone 1% - Topical for skin irritation, itching, or rash
____	____	Ibuprofen - By mouth for headache, fever, menstrual cramps, or minor pain
____	____	Saline Eye Drops - For irritation or redness of the eye
____	____	Sudafed - By mouth for nasal or sinus congestion
____	____	Tums - By mouth for nausea, heartburn, indigestion

ROUTINE MEDICATIONS: The following medications are to be dispensed to the person named above while at camp. List all medications (including both over-the-counter and prescription medications) taken routinely. Bring enough medication to last the entire time at camp. Over-the-counter medications must be delivered to camp in the original packaging. Prescription medications must be delivered to camp in pharmacy packaging that identifies the patient, prescribing physician, the name of the medication, the dosage, the route of administration, and the frequency of administration.

_____ This patient takes NO MEDICATIONS on a routine basis.

_____ This patient takes the following medications on a routine basis:

Medication	Dosage	Route	Schedule	Comments

(If more space is needed, please check here ____, and list additional medications on the back.)

Note any medications normally taken during the school year that the camper does not / may not take during the summer: _____
_____

I authorize the use of the indicated medications in the treatment of this patient.

Signature of health care provider X _____ Date_____

Printed name _____ License # _____

I have reviewed this information and agree to its accuracy, and authorize the use of the indicated medications in the care of my child.

Signature of Parent/Guardian X _____ Date _____

We are writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. New York State Public Health Law requires us to provide information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for seven or more consecutive nights. We are required to maintain a record of the following information for each camper:

- A response to receipt of information about meningococcal disease and vaccination, signed by the camper's parent or guardian.
- Information on availability and cost of meningococcal meningitis vaccine (Menomume™).
- A record of meningococcal meningitis immunization within the past 10 years, or
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Please review this material carefully, complete the Response Form (below) and return it with your child's Health Form.

Meningitis is rare. When it strikes, however, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column, as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death. Cases of meningitis among teens and young adults 15 - 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine that protects against four types of the bacteria that cause meningitis in the United States (types A, C, Y and W-135) is available. These types of bacteria account for nearly two thirds of meningitis cases among teens and young adults. Information about the availability and cost of the vaccine can be obtained from your health care provider, or by visiting the manufacturer's website at www.meningitisvaccine.com. Vanderkamp Center does not offer meningococcal immunization.

To learn more about meningitis and the vaccine, please contact your child's health care provider. You can also find information at the New York State Department of Health website (www.health.state.ny.us) and at the website of the Centers for Disease Control and Prevention (www.cdc.gov/ncidod/dbmd/diseaseinfo).

Thank you for your attention to this matter. Please let us know if you have questions or need any additional information.

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven or more consecutive nights.

Please check one box and sign below:

_ My child has had the meningococcal meningitis immunization (Menomume™) within the past 10 years.

Date received: _____

[Note: The vaccine's protection lasts approximately 3 - 5 years. Revaccination may be reconsidered within 3 - 5 years.]

_ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided that my child will not obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____

Camper's Name: _____ Date of Birth: _____

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Communicable Disease Control

Meningococcal Disease

Information for College Students and Parents of Children at Residential Schools and Overnight Camps

What is Meningococcal Disease?

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord).

Who gets Meningococcal Disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college student die each year as a result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person know to have had the disease, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without signs of illness, while others may develop serious symptoms.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Among people who develop meningococcal disease, 1015% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

Who soon do the symptoms appear?

The symptoms may appear 2 to 10 days after exposure, but usually within 5 days.

What is the treatment for meningococcal disease?

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?

Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is sage, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

How can I get more information about meningococcal disease and vaccination?

Contact your family physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncid/dbmd/disease info; and the American College Health Association, www.acha.org.