

Health Care Recommendations by Licensed Physician

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care, of a physician for the following condition(s): _____

Camper's Name: _____
 N-chok N-kiv U-chok U-kiv U2 Bulava

Current treatment – please record on *Medication Form* _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? Yes No

Does applicant have diabetes? Yes No

Recommendations and Restrictions while at Camp

Any treatment to be continued at camp? _____

Any medication to be administered at camp? Yes No **If yes, please record on *Medication Form***

Any medically - prescribed meal plan or dietary restrictions? _____

ALLERGIES: (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional health information _____

Immunization History (Copy of immunization history may be included)

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Health History
(Check: Give approximate dates.)

_____ Frequent Ear Infections
 _____ Heart Defect/Disease
 _____ Convulsions
 _____ Diabetes
 _____ Bleeding/Clotting Disorders
 _____ Hypertension
 _____ Mononucleosis Diseases
 _____ Chicken Pox
 _____ Measles
 _____ German Measles
 _____ Mumps

Allergies (Dates not needed)

_____ Hay Fever
 _____ Ivy Poisoning, etc.
 _____ Insect Stings
 _____ Penicillin
 _____ Other Drugs
 _____ Asthma
 _____ Other (*Specify*) _____

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria } Pertussis (Whooping Cough) } DPT* } Tetanus } or }	1 2 3	1 2
Tetanus } TD* Diphtheria } or }		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		
Meningococcal Meningitis		
Varicella		

I have examined: (Name of Camper) _____ Date Examined _____

In my opinion, the above camper's condition, does does not preclude his/her participation in an active camp program.

Licensed Physician's Signature _____

Address _____ Phone _____
Street & Number City State ZIP Area/Number

Date of Form Completion _____ *By _____
**Initial if completed by nurse or physician's assistant*



ВОВЧА ТРОПА

Plast Camp

Sayre Hill Road, East Chatham, New York 12060 (518) 392-5801

Dear Parent,

March 1, 2010

We are writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003.

Vovcha Tropa is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent /guardian;
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- 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.

Meningitis is rare. However, when it strikes, 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. A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States — types A, C, Y and W-135. These types 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 and by visiting the manufacturer's website at www.meningitisvaccine.com. I encourage you to carefully review the enclosed materials. **Please complete the Meningococcal Vaccination Response Form and return it along with your health forms.** To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information about the disease at the New York State Department of Health website: WWW.HEALTH.STATE.NY.US, and the website of the Center for Disease Control and Prevention (CDC), WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO.

Sincerely,
OTK - Vovcha Tropa, Plast Camp

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

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 (7) or more nights.

You must CHECK ONE BOX, sign below and return this form.

My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: _____
[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered 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. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Camper's Name: _____ Date of Birth: _____

Mailing Address: _____

Signed: _____ Date: _____
(Parent/Guardian)

Please indicate child's camp:

N-chok N-kiv U-chok U-kiv U2 Bulava



ВОВЧА ТРОПА

Plast Camp

Sayre Hill Road, East Chatham, New York 12060 (518) 392-5801

Individualized Orders for:

Camper's Name: _____ D.O.B. _____

<input type="checkbox"/> N-chok	<input type="checkbox"/> N-kiv	<input type="checkbox"/> U-chok	<input type="checkbox"/> U-kiv	<input type="checkbox"/> U2	<input type="checkbox"/> Bulava
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2010 MEDICATION FORM *as required by Columbia County, NY Dept. of Health*

Physician's Name: _____ Phone _____

Physician's Address: _____ License # _____

Physician's Signature _____ Date _____

STANDARD OVER THE COUNTER/PRN MEDICATIONS: (The following medications may be available in the infirmary and will be administered at the discretion of the RN, **ONLY IF approval is indicated with a check mark below by the camper's physician**).

DRUG NAME/ ROUTE	INDICATIONS	PLEASE CHECK MEDS CAMPER MAY RECEIVE	OTHER INDICATIONS	DRUG NAME/ ROUTE	INDICATIONS	PLEASE CHECK MEDS CAMPER MAY RECEIVE	OTHER INDICATIONS
Advil Cold & Sinus PO	As directed on packaging			Imodium AD PO	As directed on packaging		
Bacitracin ointment TOPICAL	As directed on packaging			Junior Strength Tylenol PO	As directed on packaging		
Benadryl (caps. & elixir) PO	As directed on packaging			Maalox Tabs & Liquid PO	As directed on packaging		
Burn Jel TOPICAL	As directed on packaging			Milk of Magnesia PO	As directed on packaging		
Caladryl Lotion TOPICAL	As directed on packaging			Pepto Bismol (tabs & liquid) PO	As directed on packaging		
Chloroseptic Throat Spray PO	As directed on packaging			Refresh Eye Drops OPHTHALMIC	As directed on packaging		
Children's Advil Suspension &/or chewable - PO	As directed on packaging			Regular Strength Tylenol PO	As directed on packaging		
Child. PediaCare Nightrest PO	As directed on packaging			Robitussin CF PO	As directed on packaging		
Children's Tylenol suspension &/or chewable - PO	As directed on packaging			Triaminic Cold & Cough PO	As directed on packaging		
Claritin PO	As directed on packaging			Tylenol Allergy Sinus PO	As directed on packaging		
Dimetapp Cold & Allergy PO	As directed on packaging			Tylenol Sinus PO	As directed on packaging		
Eye irrigating solution OPHTHALMIC	As directed on packaging			Tylenol Sore Throat PO	As directed on packaging		
Hydrocortisone Cream 1% TOPICAL	As directed on packaging			Vicks Nyquil PO	As directed on packaging		
Ibuprofen PO	As directed on packaging						

PRESCRIPTION MEDICATIONS:

DRUG NAME	ROUTE	DOSAGE	INDICATIONS	COMMENTS