



# ВОВЧА ТРОПА

Plast Camp

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

## МЕДИЧНА КАРТА HEALTH HISTORY FORM

ПРОСИМО ДОКЛАДНО ДРУКОМ ВИПОВНИТИ.  
PLEASE PRINT CLEARLY.

(This side to be filled by parents/guardian of minors or by adult campers/staff members themselves.)

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
*Last First Initial*

Parent or Guardian (or Spouse) \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
*Area/Number Area/Number*

Second Parent or Guardian or Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
*Area/Number Area/Number*

It not available in an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
*Street & Number City State ZIP Area/Number Area/Number*

Do you carry family medical/hospital insurance?  Yes  No **Please submit copy of insurance card.**

It so, indicate: Carrier \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Carrier Address \_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Current medications (**Additional forms required**) \_\_\_\_\_

Other diseases \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Suggestions on health related information for camp personnel \_\_\_\_\_

For Female

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_ Special Consideration \_\_\_\_\_

Important -- This Box Must be completed for Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

If for any reasons you cannot sign this, please contact camp authorities as soon as possible.

OTK 2004

# Health Care Recommendations by Licensed Physician

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

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

Current treatment (include current medications) \_\_\_\_\_

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 **Prescription Medication Section needs to be completed.** \_\_\_\_\_

Any medically - prescribed meal plan or dietary restrictions \_\_\_\_\_

Any 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.

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		

**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)

\_\_\_\_\_

\_\_\_\_\_

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

March, 2006

Dear Parent:

I am 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 or guardian; AND
- 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.

Cases of meningitis among teens and young adults 15 to 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 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](http://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](http://WWW.HEALTH.STATE.NY.US), and the website of the Center for Disease Control and Prevention (CDC): [WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO](http://WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO).

Sincerely,

OTK-Vovcha Tropa

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## **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 students die each year as 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 known to have had this 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 any 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, 10-15% 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.

#### **How 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 safe, 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 do 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](http://www.health.state.ny.us); the Centers for Disease Control and Prevention [www.cdc.gov/ncid/dbmd/diseaseinfo](http://www.cdc.gov/ncid/dbmd/diseaseinfo); and the American College Health Association, [www.acha.org](http://www.acha.org).



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**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 (7) or more nights.

Check **ONE** box and sign below.

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.

Signed: \_\_\_\_\_  
(Parent/Guardian)

Date: \_\_\_\_\_

Camper’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_



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March, 2006

Dear Parents:

Columbia County, NY Department of Health has mandated that all camps must have Individualized Orders for over the counter drugs as well as for prescription medications. Therefore, we must ask that you submit the attached form, **completed and signed by your personal physician**, with your child's/children's physical examination forms. Many of you are familiar with this type of form because many school districts already require that this form be kept on record in schools. Now, in Columbia County, all camps must have these completed forms for every camper.

Thank you for your anticipated cooperation. We look forward to seeing you this summer!

Sincerely,

OTK—Vovcha Tropa

Cc: Edward Coons  
Columbia County, NY Dept. of Health



# БОВЧА ТРОФИЯ

Plast Camp

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

Individualized Orders for: Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Physician's Name: \_\_\_\_\_

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, if approval is indicated by the camper's physician). **Please indicate yes or no for EACH medication.** Dosage: As directed on drug packaging

DRUG NAME	ROUTE (Please specify preferred formulation(s))	Camper Health Care Provider Order (Must Circle One)	SCHEDULE AND INDICATIONS	COMMENTS
Advil Cold & Sinus PO	PO	Yes No		
Bacitracin ointment	Topical	Yes No		
Benadryl caps. & elixir	PO	Yes No		
Burn jel	Topical	Yes No		
Caladryl lotion	Topical	Yes No		
Chloroseptic Throat Spray	PO	Yes No		
Children's Advil Suspension &/or chewable	PO	Yes No		
Child. PediaCare Nightrest	PO	Yes No		
Children's Tylenol suspension &/or chewables	PO	Yes No		
Claritin	PO	Yes No		
Dimetapp Cold & Allergy	PO	Yes No		
Eye irrigating solution	Ophthalmic	Yes No		
Hydrocortisone Cream 1%	Topical	Yes No		
Ibuprofen	PO	Yes No		
Imodium AD	PO	Yes No		
Junior Strength Tylenol	PO	Yes No		
Maalox tabs & Liquid	PO	Yes No		
Milk of Magnesia	PO	Yes No		
Pepto Bismol tabs & liquid	PO	Yes No		
Refresh eye drops	Ophthalmic	Yes No		

