Bobua TIIpona
Sayre Hill Road, East Chatham, NY 12060 • (518) 392-5801 • www.vovchatropa.org

## <mark>МЕДИЧНА КАРТА / CAMPER HEALTH HISTORY</mark>

TO BE FILLED OUT BY PARENTS/GUARDIANS OR BY ADULT CAMPERS/STAFF MEMBERS THEMSELVES. PLEASE PRINT CLEARLY.

Parents   Pare	Camper Name			Birtl	n date	Sex	Age
Home Address   Street & Number   City   State   ZIP   Home Phone		Middle Initial	Last				-
Operations or serious injuries (dates).  Name of dentist/orthodomist  Phone  Address of primary physician  Phone  Fax #:  Suggestions on health related information for camp personnel  For Female: Has this person menstruated?  If not, has she been told about it?  MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE  Meningococcal disease, is a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Hea Law requires all parents of children attending overnight camps of 7 or more nights to be informed of this serious bacterial infection. If not treate early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as the vaccine and be obtained from your health care provider or you can visit the following websites: www.meningitis, the vaccine, and to the vaccine can be obtained from your health care provider or you can visit the following websites: www.meningitisvaccine.com_and the website the vaccine can be obtained from your health care provider or you can visit the following websites: www.meningitisvaccine.com_and the website the vaccine can be obtained from your health care provider or you can visit the following websites: www.meningitisvaccine.com_and the website the vaccine can be obtained from your health care provider or you can visit the following websites: www.meningitisvaccine.com_and the website the vaccine can be obtained from your health care provider or you can visit the following websites: www.meningitisvaccine.com_and the website the vaccine can be obtained from your health care.  Parents, you must CHECK ONE BOX:  My child has had the meningococcal conjugate vaccine (MCV4), for example Menactra <sup>TM</sup> or Menveo <sup>TM</sup> .  Date received:  Note: The CDC recommend 2 doses of MCV4 for all adolescents 11-18 yrs. of control and prevention (CDC).  This read or a read of the fluid will not obtain immunization against meningococcal meningitis disease.  Do you carry family medical/hospital in	Parent(s) or Guardian(s)						
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Name of primary physician							
Name of primary physician	Operations or serious injuries (	(dates)					
Address of primary physician	Name of dentist/orthodontist_				Phone_		
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If for any reasons you cannot sign this, please contact camp authorities as soon as possible.

## CAMPER HEALTH RECORD – TO BE COMPLETED BY LICENSED PHYSICIAN

Camper Name:							
Date of Examination:	Age	e of Camper	Height	Weight	Blood Pre	essure	
Date of last Tetanus immuniza Medical History/additional info							
Explanation of any reported loss	s of consciousn	ess or concussion:					
Does applicant have any of the	following:	asthma 🗌 diab	etes 🗌	enuresis epileps	y 🔲 last seizure:		
Does applicant have any behavi	oral problems?	(i.e. ADD, ADHD, au	ıtism, autisn	spectrum, OCD)			
Does applicant have any psychi-	atric problems?	(i.e. anxiety, depressi	ion)				
Any treatment to be continued a	it camp?						
Any medically-prescribed meal	plan or dietary	restrictions?					
ALLERGIES: (food, NUTS, REACTION:						PLEASE ✓ IF CAMPER REQUIRES EPI PEN	
The following medications will doctor on duty: burn jel, calamizinc oxide, artificial tears, eye in	ne lotion, hydro rrigating solution	ocortisone cream, baci on, swimmers ear, oraj	tracin ointm jel.		intiseptic, medicai	ine swab, benadryl spray	
DRUG NAME/ROUTE		DOCTOR: PLEASE  ✓ MEDS BELOW CAMPEI  MAY RECEIVE	R	DRUG NAME/ROUTE		DOCTOR: PLEASE  MEDS BELOW  CAMPER MAY RECEIVE	
Loratidine			Topical	Topical Anti-fungal ointment			
Cetirizine HCl			Antacio	Antacid/Antigas			
Diphenhydramine			Stool So	Stool Softener			
Acetaminophen			Tums c	Tums chewable			
Ibuprofen			Midol	Midol			
Dextromethorphan			Throat	Spray/lozenges			
Decongestant			Pepto E	ismol			
Camper <u>may not</u> have	e the follo	wing medication	ons:				
PRESCRIPTION M	EDICATI	ONS Allergy to N	leds:	/	Reaction:		
DRUG NAME ROUTE		DOSAGE		INDICATIONS		COMMENTS	
In my oninion, the above can	nner's conditi	on $\square$ does $\lceil$	does no	t nreclude his/her na	rticination in an	active camp program	
In my opinion, the above can	nper's conditi	on,	does no	t preclude his/her par	rticipation in an	active camp program	
Licensed Physician's Signature	nper's conditi	on,	does no	t preclude his/her par	rticipation in an	active camp program	
	nper's conditi	on,	does no	t preclude his/her par	rticipation in an	active camp program.  ZIP	