Вовча Тропа
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МЕДИЧНА КАРТА / CAMPER HEALTH HISTORY

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

Camper Name _____ Birth date _____ Sex _____ Age _____
First Middle Initial Last

Parent(s) or Guardian(s) _____

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

Operations or serious injuries *(dates)* _____

Name of dentist/orthodontist _____ Phone _____

Name of primary physician _____ Phone _____

Address of primary physician _____ 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 Health Law requires all parents of children attending overnight camps of 7 or more nights to be informed of this serious bacterial infection. 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, strokes, limb amputation, and even death. Meningococcal conjugate vaccine (MCV4) is the preferred vaccine for people 55 years of age and younger. Two MCV4 vaccines are Menactra™ and Menveo™. Information about meningitis, the vaccine, and cost of the vaccine can be obtained from your health care provider or you can visit the following websites: www.meningitisvaccine.com and the website of the Center for Disease Control and Prevention (CDC), www.cdc.gov/vaccines/vpd-vac/mening/default.htm;

Parents, you must CHECK ONE BOX:

☐ My child has had the meningococcal conjugate vaccine (MCV4), for example Menactra™ or Menveo™.
Date received: _____ *Note: The CDC recommend 2 doses of MCV4 for all adolescents 11-18 yrs. of age.*

☐ 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.

Do you carry family medical/hospital insurance? ☐ Yes ☐ No ***PLEASE ATTACH FRONT AND BACK COPY OF INSURANCE & PRESCRIPTION CARD***

If NO, please fill out "No Insurance Form" and send in with application paperwork.

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 _____

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 of Camper**_____ **Height** _____ **Weight** _____ **Blood Pressure** _____

Date of last Tetanus immunization: _____ Any limitations to activities?_____

Medical History/additional info: _____

_____

Explanation of any reported loss of consciousness or concussion:_____

Does applicant have any of the following: asthma ☐ diabetes ☐ enuresis ☐ epilepsy ☐ last seizure: _____

Does applicant have any behavioral problems? (i.e. ADD, ADHD, autism, autism spectrum, OCD) _____

Does applicant have any psychiatric problems? (i.e. anxiety, depression) _____

Any treatment to be continued at camp? _____

Any medically-prescribed meal plan or dietary restrictions? _____

ALLERGIES: ***(food, NUTS, plants, insects, etc.)*** _____

REACTION: _____

_____ **PLEASE ✔ IF CAMPER REQUIRES EPI PEN**

STANDARD O-T-C MEDICATIONS PROVIDED PRN

The following medications will be administered as first aid as directed on packaging, based on child's weight and age, at the discretion of the RN or doctor on duty: burn jel, calamine lotion, hydrocortisone cream, bacitracin ointment, Neosporin, betadine antiseptic, medicaine swab, benadryl spray, zinc oxide, artificial tears, eye irrigating solution, swimmers ear, orajel.

DOCTOR APPROVAL NEEDED – approval must be indicated with a check mark (✔) below:

DRUG NAME/ROUTE	DOCTOR: PLEASE ✔ MEDS BELOW CAMPER MAY RECEIVE	DRUG NAME/ROUTE	DOCTOR: PLEASE ✔ MEDS BELOW CAMPER MAY RECEIVE
Loratidine		**Topical Anti-fungal ointment**	
Cetirizine HCl		**Antacid/Antigas**	
Diphenhydramine		**Stool Softener**	
Acetaminophen		**Tums chewable**	
Ibuprofen		**Midol**	
Dextromethorphan		**Throat Spray/lozenges**	
Decongestant		**Pepto Bismol**	

Camper may not have the following medications: _____

PRESCRIPTION MEDICATIONS *Allergy to Meds:_____Reaction: _____*

DRUG NAME	ROUTE	DOSAGE	INDICATIONS	COMMENTS

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: _____
Street & Number *City* *State* *ZIP*

Phone _____ Date of Completion: _____ Please initial if completed by nurse or PA: _____

****** PLEASE ATTACH IMMUNIZATION HISTORY ******