Health History and Examination Form for Children, Youth and Adults Attending Plast Camps

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.
(This side to be filled by parents/guardian of minors or by adult campers/staff members themselves.)

Name _____ Birthdate _____ Sex _____ Age _____
Last First Initial

Parent or Guardian (or Spouse) _____

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

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

Second Parent or Guardian or Emergency Contact _____

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

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

It not available in an emergency, notify

Name _____

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

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)*

Operations or serious injuries *(dates)* _____

Chronic or recurring illness or medical condition _____

Dietary restrictions _____

Current medications *(send with instructions)* _____

Other diseases _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Do you carry family medical/hospital insurance? ☐ Yes ☐ No

It so, indicate: Carrier _____ Policy or Group # _____

Carrier Address _____

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 religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.

Name:

Date Examined:

Camp:

Year:

Immunization History

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	Yew of Last Booster
Diphtheria Pertussis (Whooping Cough) } DPT* Tetanus or	1 2 3	1 2
Tetanus Diphtheria } TD* 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		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant. Date Examined _____

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

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 *(specific dosages)* _____

_____

Any medically - prescribed meal plan or dietary restrictions _____

_____

Any allergies *(food, drugs, plants, insects, etc.)* _____

_____

Activities to be encouraged or limited _____

_____

Additional health information _____

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*

Emergency Medical Services
Authorization for Medical Treatment of Minors

Name of Minor	**Birth Date**	**Identify Allergies or Special Conditions**

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

Name: **Plast Camp Representative**	**Address:** **2301 School St.** **North Collins, NY 14111**	**Phone:** **(716) 337-3361**
Name:	**Address:**	**Phone:**

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from (dates): _____ to _____.

Signature of Authorized Person: _____.

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Parent/Guardian Signature	**Parent/Guardian Signature**
Address	Address
Date	Date

Witness Signature	**Witness Signature**
Date	Date

Hospitalization / Insurance coverage for above named minor(s):

Insurance Company or Government Program	ID or Contract Number

Family Physician(s)

Name and Phone Number	Name and Phone Number

Fill out the above form carefully having your signature witnessed by someone other than the person you are designating to be responsible.

Plast Camp – “Novyi Sokil”
2301 School Street
North Collins, NY 14111

OVER THE COUNTER MEDICATION RELEASE

Individualized orders for (camper’s name): _____
Date of birth: _____

I grant the Plast Camp “Novyi Sokil” medical staff (EMT) permission to decide if (camper’s name) _____ needs to be treated with over the counter drugs such as Advil, aspirin, etc. The over the counter drugs which have been provided for the camper include (please list all drugs provided for the camper):

_____
_____
_____
_____
_____
_____

The child stated above is not to be given the following due to allergic reactions or restrictions (please list all that apply):

_____
_____
_____

This release is only for over the counter medications. All prescription medications are documented on the camper’s medical form.

Signature of Camper’s Parent: _____ Date: _____

Signature of Camper’s Physician: _____Date: _____

Name of Physician: _____

Physician’s Address: _____

THIS FORM IS REQUIRED BY THE ERIE COUNTY NEW YORK HEALTH DEPARTMENT IN ORDER TO RECEIVE MEDICATION. If this form is not filled out and signed by a physician and the camper’s parent, no medication will be dispensed to the camper named above.

Plast Camp “Novyi Sokil”
2301 School Street
North Collins, NY 14111

OVERNIGHT CHILDREN’S CAMP
PARENT LETTER

Dear Parent:

We are writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Health Law (NYS PHL) §2167 and Subpart 7-2 of the State Sanitary Code requires overnight children’s camps to distribute information about meningococcal disease and vaccination to all campers who attend camp for 7 or more consecutive nights.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illness such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, and limb amputation, in as many as one in five of those infected. Ten to 15 percent of those who get meningococcal disease will die.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that cause meningococcal disease even before they know they are sick.

Anyone can get meningococcal disease, but certain people are at increased risk including teens and young adults 16 – 23 years old and those with certain medical conditions that affect the immune system.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause meningococcal disease in the United States. The Centers for Disease Control and Prevention (CDC) recommends a single dose of MenACWY vaccine at age 11 through 12 years with a booster dose given at age 16 years. Children are not routinely recommended to receive MenACWY vaccine prior to the recommended ages, unless they have certain underlying medical conditions which increase their risk of disease. The meningococcal B (MenB) vaccine protects against a fifth strain of meningococcal bacteria which causes meningococcal disease. Young

adults aged 16 through 23 years may be vaccinated with MenB vaccine and should discuss the MenB vaccine with a healthcare provider.

We encourage you to carefully review the attached Meningococcal Disease Fact Sheet. It is also available on the New York State Department of Health website at: http://www.health.ny.gov/publications/2168.pdf.

Information about the availability and cost of meningococcal vaccine can be obtained from your healthcare provider or your local health department.

Plast Camp "Novyi Sokil" is required to maintain a record for each camper, signed by the camper's parent or guardian, which documents the following:

- Receipt and review of meningococcal disease and vaccine information; AND EITHER
- Certification that the camper has been immunized against meningococcal meningitis within the past 10 years; OR
- An understanding of meningococcal disease risks and benefits of vaccination at the recommended ages and the decision not to obtain immunization against meningococcal meningitis at this time.

Please complete the enclosed Meningococcal Meningitis Vaccination Response Form and return it with your camp registration forms.

To learn more about meningococcal meningitis and the vaccine, please feel free to contact and/or consult your child's physician. You can also find information about the disease at the website of the Centers for Disease Control and Prevention: www.cdc.gov/vaccines/vpd-vac/mening/default.htm.

Sincerely,

PLAST – Ukrainian Scouting Organization
Plast Camp "Novyi Sokil"

Plast Camp "Novyi Sokil"
2301 School Street
North Collins, NY 14111

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

The Centers for Disease Control and Prevention recommends two doses of MenACWY vaccine (Brand names: Menactra, Menveo) for all healthy adolescents 11 through 18 years of age: the first dose is given at 11 or 12 years of age, with a booster dose at 16 years of age. Children and adolescents with certain medical conditions may need to begin the MenACWY series at a younger age and/or receive additional doses. Consult with your child's healthcare provider regarding any medical conditions they may have.

If the first dose is given between 13 and 15 years of age, the booster should be given between 16 and 18 years of age. If the first dose is given after the 16th birthday, a booster is not needed.

Young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series (Brand names: Trumenba, Bexsero). Parents/guardians should discuss the Meningococcal B vaccine with a healthcare provider.

Check one box and sign below.

☐ I have received and reviewed the information regarding meningococcal meningitis. My child has received meningococcal immunization (Menactra or Menveo) within the past 10 years.

Date received: _____

OR

I have received and reviewed the information regarding meningococcal meningitis. I understand the risks of meningococcal meningitis and the benefits of immunization at the recommended ages.

☐ I have decided that **my child**, who is **younger than 11 years of age**, will **not** obtain immunization against meningococcal disease at this time; or

☐ I have decided that **my child**, who is **11 years of age or older**, will **not** obtain immunization against meningococcal disease at this time.

Signed: _____ Date: _____
(Parent / Guardian)

Camper's Name: _____ Date of Birth: _____

Mailing Address: _____

Parent/Guardian's E-mail Address (optional): _____

Будь ласка, долучіть копі переду і заду вашої страхової та рецептної картки.

Please attach copies of the front and back of your insurance and prescription card.