

Camper Last Name, First Name: _____

General Questions (Explain "yes" answers below.)

Has or does the participant:

Yes	No			Yes	No
		Had any recent injury, illness or infectious disease?	Ever had problems with joints? (e.g. knees, ankles)		
		Have a chronic or recurring illness/condition?	Have an orthodontic appliance being brought to camp		
		Ever been hospitalized?	Have any skin problems? (e.g. itching, rash, acne)		
		Ever had surgery?	Have diabetes?		
		Have frequent headaches?	Have asthma?		
		Ever had a head injury?	Had mononucleosis in the past 12 months?		
		Ever been knocked unconscious?	Had problems with diarrhea/constipation?		
		Wear glasses, contacts, or protective eye wear?	Have problems sleepwalking?		
		Ever had frequent ear infections?	If female, have an abnormal menstrual history?		
		Ever passed out during or after exercise?	Have a history of bed -wetting?		
		Ever been dizzy during or after exercise?	Ever had an eating disorder?		
		Ever had seizures?	Ever had emotional difficulties for which professional help was sought?		
		Ever had chest pain during or after exercise?	Ever been diagnosed with a heart murmur?		
		Ever had high blood pressure?	Ever had back problems?		

Explain any "yes" answers, noting the questions.

Which of the following has the participant had?

<input type="checkbox"/>	Measles	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	TB Mantoux Test Date of last test _____ Result: ___ Positive ___ Negative

Please give all dates of immunizations for:

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	M
DTP							MMR							
TD (tetanus/diphtheria)							Or Measles							
Tetanus							Or Mumps							
Polio							Or Rubella							
Hepatitis B							Haemophilus Influenza B							
Varicella (chicken pox)														

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp health staff and/or director should be aware.

Name of family dentist/orthodontist: _____ Phone: _____

Address _____

Camper Last Name, First Name: _____

Health Care Recommendations by Licensed Medical Personnel

MUST BE COMPLETED BY A DOCTOR

(A physical generated by the camper's health care provider may be used in place of this page **however the health care provider *must* fill out the medication authorization forms at the bottom of this and on the following page)**

I examined _____ on _____. BP _____ Weight _____ Height _____
(Camper/Individual's Name) (Date of exam (within 1 year of first day attending camp))

(NYS Health Department requires annual exams. A new exam is not necessarily required for camp attendance.)

In my opinion, the above applicant ___ is ___ is not (*check one*) able to participate in an active camp program.

Recommendations and Restrictions at Camp:
(Treatment to be continued at Camp)

Known Allergies:

Any medically prescribed meal plan or dietary restrictions?

Additional Information for health care staff at camp:

Has camper/patient had recent (with in 30 days of attendance) alteration to medication and/or treatment?

Prescription and OTC Medications to be Administered at Camp (Please complete with patient's current regimen for both scheduled and PRN medications. Use second sheet if necessary.)

_____ NONE (*check here if no medications are being brought to camp*)

_____ (Please read & initial) **IMPORTANT: ALL medications (prescription and over the counter including vitamins) MUST** be in the original bottle with child's name, dosage and schedule and indications that match the instructions indicated in the "prescription Medications to be Administered at Camp" section of this form, signed by your physician or an attached copy of the prescription.

Drug Name	Route	Dosage	Schedule & Indications	Comments
	Oral Topical			
	Oral Topical			
	Oral Topical			
	Oral Topical			
	Oral Topical			



Signature of Camper's Health Care Provider _____


PrintedName _____ Title _____ License# _____

Camper Last Name, First Name: _____

MUST BE COMPLETED BY A DOCTOR

STANDARD OVER THE COUNTER/PRN MEDICATIONS (The following medications are available in the Camp Health Office and will be administered at the discretion of an RN, if approval is indicated by the camper's Healthcare provider.)


Drug Name	Route <i>(please circle preferred formulation)</i>	Dosage	Schedule & Indications <i>(please circle all that apply)</i>	Healthcare Provider Order <i>(please circle one)</i>	Comments
Sunscreen/Sun Block	topical	As per package instructions	As needed	Yes No	
Chap Stick/Lip Balm	topical	As per package instructions	As needed	Yes No	
Bug Spray	topical	As per package instructions	As needed	Yes No	
Antiseptic Ointment	topical	As per package instructions	Minor wound care other:	Yes No	
Anti-itch Ointment	topical	As per package instructions	Rashes insect bites other:	Yes No	
Anti-Sting Ointment	topical	As per package instructions	Insect bites other:	Yes No	
Antibiotic Ointment	topical	As per package instructions	Minor wound care other:	Yes No	
Sunburn Relief Ointment	topical	As per package instructions	Sunburn other:	Yes No	
Ibuprofen	Oral: tablet or liquid	As per package instructions	Pain swelling fever other:	Yes No	
Acetaminophen	Oral: tablet or liquid	As per package instructions	Pain swelling fever other:	Yes No	
Anti-fungal Cream	topical	As per package instructions	Athletes foot other:	Yes No	
Antacid/Antiemetic	Oral: tablet or liquid	As per package instructions	Nausea diarrhea other:	Yes No	
Swimmer's Ear Drops	topical	As per package instructions	Ear pain after swimming other:	Yes No	
Eye Drops	topical	As per package instructions	Eye irritation allergies other:	Yes No	
Hydrocortisone 0.5%	topical	As per package instructions	Rashes insect bites poison ivy other:	Yes No	
Cough Syrup	oral	As per package instructions	Coughing other:	Yes No	
Laxative	Oral: tablet or liquid	As per package instructions	Constipation other:	Yes No	
Antihistamine Claritin (or its generic)	Oral topical	As per package instructions	Swelling hives allergic reactions nasal congestion allergy relief other:	Yes No	
Benadryl	Oral: tablet or liquid	As per package instructions	Swelling hives allergic reactions nasal congestion allergy relief other:	Yes No	
Anti-diarrhea	Oral: tablet or liquid	As per package instructions	Diarrhea other:	Yes No	
Lice Shampoo	topical	As per package instructions	Lice or Nits	Yes No	

 Signature of Camper's Health Care Provider _____

PrintedName _____ Title _____ License# _____

Parent Authorization The following must be completed by parent/guardian.

I, _____, hereby request that the staff of YMCA Buffalo Niagara supervise my child, _____ taking the above medication or applying topical items as indicated as part of the Summer Camp Program.

 _____
 Parent/Guardian Signature _____ Date _____

Camper Last Name, First Name: _____

MENINGITUS FORM

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.

YMCA Camp Weona 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.

I encourage you to carefully review the enclosed materials. **Please complete the Meningococcal Vaccination Response Form and return it to:**

YMCA Camp Weona
301 Cayuga Road
Buffalo, NY 14225

To learn more about meningitis and the vaccine, please feel free to 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,



Executive Director
YMCA Camp Weona

Camper Last Name, First Name: _____

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: _____ Date: _____
(Parent / Guardian)

Camper's Name: _____ Date of Birth : _____

Mailing Address: _____

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

**NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Communicable Disease Control**

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; the Centers for Disease Control and Prevention www.cdc.gov/ncid/dbmd/diseaseinfo; and the American College Health Association, www.acha.org.