

## **WORD OF LIFE CAMPS- The following are steps to guide you through our camp medical forms**

### **STEP # 1 – Complete Required Forms**

- Health & Activity Record:** Parent or Guardian must complete, sign & date this form.
- Medication Form:**
  - Required if your camper is to take medication in any form while at camp, including prescription medication, over-the-counter-medicine, vitamins, herbs, or dietary supplements.
  - Must be completed and signed by a licensed health care provider (authorized to prescribe medications).
  - Without this form, your camper will not receive any medication while at camp.
- Meningococcal Meningitis Vaccination Response:** *If your camper is staying seven or more nights at camp*, New York State Public Health Law requires Word of Life to inform and warn of the risks of Meningitis as well as maintain documentation for each camper (see Meningitis Fact Sheet, if applicable).

### **STEP # 2 – Return the Forms** -- Make a copy of all completed forms for your records.

- 1) **If camper is registered with a Group,** please return completed forms to Group Leader.

**GROUP LEADERS:** Please collect, alphabetize and return the Health & Activity Records, Medication Forms, and Meningitis Response Forms (if applicable) for all campers in your group.

**Check to make sure:**

- The same Group and Leader Information is on all forms and that the correct Camp and Dates have been selected.
- Parent or guardian signature is on the Health and Activity Record.

- 2) **If camper is registered as an individual,** please mail completed forms two or more weeks prior to arrival to:

**US MAIL**

WOL Camp Registrar  
P.O. Box 600  
Schroon Lake, NY 12870

**UPS OR FEDEX**

WOL Camp Registrar  
71 Olmsteadville Road  
Pottersville, NY 12860

**If you are unable to meet the two-week deadline, the forms may be brought to camp and turned in at Registration.**

### **STEP # 3 – Camp Preparation**

- Medications:**
  - Medication must be in the original container.
  - Keep medication separate from luggage; all medications must be turned in at Registration and given to Camp Nurse upon arrival.
  - Campers with medications must be present at Registration to talk to one of the nurses and set up their medication schedule. Campers without medications should not come through the registration line.
  - Note: Campers who are cognitively and physically able to demonstrate proper and mature use of emergency medications such as epi-pens and inhalers may keep them during camp. All other medications must be turned into the nurse.
  - Health Screening – All campers will be screened in accordance with the “No-Nit” policy. Campers found with active cases of head lice will not be admitted to camp.

**QUESTIONS:** If you have any questions concerning the above, please contact the Health Center at 518-494-1423 or [healthcenter@wol.org](mailto:healthcenter@wol.org).



# HEALTH AND ACTIVITY RECORD

<b>OFFICE USE ONLY</b> Date received _____ Completed Yes or No _____ Nurse Initials _____
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**INSTRUCTIONS:** Print clearly. Please complete, sign, and date this form for all campers.

**If coming with a Group, please give to Group Leader. If coming individually, please mail to Word of Life Camp Registrar, PO Box 600, Schroon Lake, NY 12870.**

<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>	<b>Camp Attending</b>	
			<input type="checkbox"/> Snow Camp <input type="checkbox"/> Ranch <input type="checkbox"/> Island <input type="checkbox"/> Campus Days	
<b>DATE OF BIRTH</b>	<b>MALE</b>	<b>FEMALE</b>		<b>DATES ATTENDING CAMP</b>
	<input type="checkbox"/>	<input type="checkbox"/>		
<b>List Church or Group and Leader Information below (if applicable)</b>				
<b>Church/Group Name, City &amp; State:</b>			<b>Group Leader:</b>	
<b>Location and phone number where leader is staying during camp:</b>				
<b>Parent or Guardian</b>	<b>List Parent or Guardian's Full Name &amp; Complete Address below</b>		<b>Telephone Numbers with Area Codes</b>	
	Name:		Home: (    )	
	Address:		Work: (    )	
	City:	State:	Zip Code:	Cell: (    )
<b>IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES)</b>			<b>Telephone Numbers with Area Codes</b>	
Name:			(    )	
Name:			(    )	
<b>Are you covered by Medical Insurance?</b>  Yes    No <b>If yes, please complete insurance info at right and include copy of medical insurance cards (front and back)</b>	Name of Company		Policy Number	
	Group Number		Telephone Number	
			(    )	
	Parents/Guardian Social Security Number (Required by Medical Facilities if under 18 years old)			
Parent/Guardian Name:		Social Security No:		
<b>ALLERGIC TO:</b> <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Aspirin <input type="checkbox"/> Other				
<b>ANY FOOD OR OTHER ALLERGIES?</b> If yes, please explain.				
<b>MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE</b>				
New York State Public Health Law requires Word of Life camps to maintain a completed Response Form for every camper who attends camp for seven (7) or more nights.				
<b>Check one box</b>				
<input type="checkbox"/> My child has had the meningococcal meningitis immunization (Menomune™) or (Menactra) <div style="text-align:right;">Please circle one</div>				
<b>Date received:</b> _____				
<input type="checkbox"/> 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 <b>not</b> obtain immunization against meningococcal meningitis disease.				

**Camper's Name** \_\_\_\_\_

**IF CAMPER HAS HAD OR CURRENTLY HAS ANY OF THE FOLLOWING PLEASE CHECK THE BOX AND INCLUDE YEAR OF OCCURRENCE:**

- |   |   |  |
|---|---|--|
| _____ <input type="checkbox"/> Anemia           | _____ <input type="checkbox"/> Asthma                     | _____ <input type="checkbox"/> Kidney Disease              |
| _____ <input type="checkbox"/> Chicken Pox      | _____ <input type="checkbox"/> Epilepsy                   | _____ <input type="checkbox"/> Chronic Intestinal Problems |
| _____ <input type="checkbox"/> Diabetes         | _____ <input type="checkbox"/> Seizures                   | _____ <input type="checkbox"/> Polio                       |
| _____ <input type="checkbox"/> Measles          | _____ <input type="checkbox"/> Bed Wetting                | _____ <input type="checkbox"/> Frequent Colds              |
| _____ <input type="checkbox"/> Mumps            | _____ <input type="checkbox"/> Tuberculosis or TB Contact | _____ <input type="checkbox"/> HIV Positive                |
| _____ <input type="checkbox"/> Rubella (German) | _____ <input type="checkbox"/> Frequent Sore Throats      | _____ <input type="checkbox"/> Orthopedic Problems         |
| _____ <input type="checkbox"/> Hepatitis A      | _____ <input type="checkbox"/> Hearing Problems           | _____ <input type="checkbox"/> Operations                  |
| _____ <input type="checkbox"/> Hepatitis B      | _____ <input type="checkbox"/> Speech Defect              | _____ <input type="checkbox"/> Emotional Treatment         |
| _____ <input type="checkbox"/> Hepatitis C      | _____ <input type="checkbox"/> Mononucleosis              | _____ <input type="checkbox"/> Malaria                     |
|   |   | _____ <input type="checkbox"/> Other _____                 |

Able to Pursue All Normal Activities? If not explain: \_\_\_\_\_

Name of Family Physician or Medical Group: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Dentist or Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

- If camper has been immunized for any of the following, please attach proof of immunization OR provide dates for recommended vaccines below.

IMMUNIZATION HISTORY		1st Dose	2nd Dose	3rd Dose	4th Dose	Last Dose
<b>Diphtheria &amp; Tetanus (DTP, DTap, Pertussus, Td)</b> Most recent dose should be within 10 years.						
<b>Polio</b>						
<b>Note dates of actual diseases in section above.</b>	<b>MMR</b>					
	<b>Or Measles</b>					
	<b>Or Mumps</b>					
	<b>Or Rubella</b>					
	<b>Hepatitis B</b>					
	<b>Haemophilus Influenza B</b>					
	<b>Varicella (Chicken Pox)</b>					

**Early Departure Information:** Campers needing to leave early must be picked up by parent (s) or guardian (s) who sign this form. Anyone other than the parent/guardian must have written permission signed by parent/guardian who has signed this form. The camp reserves the right to refuse dismissal without proper identification.

The health and immunization history is correct so far as I know. My son/daughter has permission to engage in all prescribed camp activities which may include but are not limited to horseback riding, water sports, water skiing, skate park (if applicable), except as noted by me and the examining physician and has permission to leave the camp grounds for camp-related outings and purposes. I realize that my camper's picture and/or testimony may be used in the future promotion of Word of Life.

Word of Life Camps is a non-profit charitable organization dependent on God and His people. Those who use Word of Life's facilities and/or engage in related activities waive and release Word of Life Fellowship, Inc. from any claim for personal injury or property damage. Attendees agree to carry insurance and/or cover the expenses related to personal injury or property damage.

**I understand that all medicines, vitamins, etc. must be given to the camp nurse upon arrival and that they must be in the original containers. No medication may be given without the MEDICATION FORM completed and signed by my child's health care provider.** Illegal drugs, weapons and similar items are not permitted at camp. Word of Life reserves the right to search for and remove such items from anyone suspected of possessing them.

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my son/daughter. In the event I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for my child as named above. This form may be photocopied for use out of camp.

**Signature of Parent or Guardian:** \_\_\_\_\_

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

**Print Name Here:** \_\_\_\_\_

**Word of Life Camp  
Individual Medication Order Form (Signature required by Physician)**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

The following may be administered to your child, if needed, while at camp. A physician's signature and approval is required.

<b>Medication Order</b>	<b>Dosage</b>	<b>Physician Approval</b>
		<b>Please check Yes or No</b>
Acetaminophen (Compared to active ingredient in Tylenol)	per label instructions by age/wt	Yes____ or No____
Ibuprofen (Compared to active ingredient in Advil)	per label instructions by age/wt	Yes____ or No____
DiphenhydramineHCl (Compared to active ingredient in Benadryl)	per label instructions by age/wt	Yes____ or No____
Guaifenesin usp (Compared to active ingredient in Robitussin)	per label instructions by age/wt	Yes____ or No____

**Parent/guardian, please list your child's prescription medications, vitamins, herbs and or dietary supplements, as ordered by the child's physician. A physician's signature is required for the camp nurse to administer medication(s) to your child.**

Medication Name	Route	Dosage	Frequency and Indications	Comments

Additional Physician orders:

Signature of approving licensed health care provider authorized to prescribe medications.

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

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone number with area code: \_\_\_\_\_

If you have any questions concerning this form, call Word of Life Health Services at: 518-494-1423.

*If you want the camp nursing staff to be able to administer even basic Tylenol to your child, you must have a Physician's signature on this form.*

## Meningococcal Disease Information Sheet

**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) caused by the meningococcus germ.

**Who gets meningococcal disease?** Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first year college students living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease. Other persons at increased risk include household contacts of a person known to have had this disease, immunocompromised people, and people traveling to parts of the world where meningococcal meningitis is prevalent.

**How is the meningococcus germ spread?** The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

**What are the symptoms?** High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. 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.

**What is the treatment for meningococcal disease?** Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

**Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated?** Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (either rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

**Is there a vaccine to prevent meningococcal meningitis?** In February 2005 the CDC recommended a new vaccine, known as Menactra™ for use to prevent meningococcal disease in people 11-55 years of age. The previously licensed version of this vaccine, Menomune™ is available for children 2-10 years old and adults older than 55 years. Both vaccines are 85% to 100% effective in preventing the 4 kinds of the meningococcus germ (types A, C, Y, W-135). These 4 types cause about 70% of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

**Is the vaccine safe? Are there adverse side effects to the vaccine?** Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

**Who should get the meningococcal vaccine?** The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers and travelers to endemic areas of the world.

**What is the duration of protection from the vaccine?** Menomune™, the older vaccine, requires booster doses every 3 to 5 years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster doses.

**How do I get more information about meningococcal disease and vaccination?** Contact your 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/ncidod/diseases/index.htm](http://www.cdc.gov/ncidod/diseases/index.htm); and the American College Health Association, [www.acha.org](http://www.acha.org)

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