

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 for camp. Later submissions must be hand carried.

US MAIL

WOL Camps Health Services
P.O. Box 600
Schroon Lake, NY 12870

UPS OR FEDEX

WOL Camps Health Services
4200 Glendale Rpd
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 may keep inhalers, creams, ointments and epi-pens, but must report those items to the nurse at Registration.
 - 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.

Word of Life Health and Activity Record



Camper Information

Instructions: Print Clearly. Please complete, sign and date this form for all campers. *All fields are required.*

Name _____
LAST FIRST MIDDLE

Dates Attending Camp: _____ / _____ / _____
MM DD-DD YYYY

Gender: Male Female Date of Birth: _____ / _____ / _____
MM DD YYYY

Island Ranch/Ranger
 Snow Camp Florida Youth Camp

How many weeks? _____

List Parent or Guardian's Full Name & Contact Information Below

Parent Guardian Name: _____
LAST FIRST

Cell/Work: (____) _____ - _____

Address: _____

Home: (____) _____ - _____

Emergency Contact Information

Name: _____
LAST FIRST

Relationship to Camper: _____

Cell: (____) _____ - _____ Home: (____) _____ - _____

Alternative: (____) _____ - _____

Group Information

If attending with church group or other organized group this information must be completed.

Name of Church or Group: _____

Group Leader: _____

Church/Group Address: _____

Leader Cell: (____) _____ - _____

Leader accommodation and accommodation phone number: _____

Insurance Information

Do you have Health Insurance? Yes No

Name of Company	Policy Number
Group Number	Telephone Number (____) _____
Parent/Guardian Name:	

Meningococcal Meningitis Vaccination Response

Check one statement regarding the Meningococcal Meningitis vaccine

- I have (my child has) had the meningococcal meningitis immunization within the past 10 years. **Refer to documentation in immunization record.**
 I have (my child has) read, or have had explained to me information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Response and Consent

Read and sign:

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 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. I hereby give my permission to release information to designated youth leader with my child during this week of camp.

I hereby give my 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: _____
(PARENT/GUARDIAN IF CAMPER IS A MINOR)

Date: _____ / _____ / _____
MM DD YYYY

Print Name: _____

Print Camper's Name: _____

Confidential Personal Health History Report

Does your child have any food/drug/environmental allergies? Yes No If yes please explain: _____

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"/> Malaria | <input type="checkbox"/> Chronic Intestinal Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Orthopedic Problems | <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"/> Operations |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Emotional Treatment |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Speech Defect | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Mononucleosis | |

Has your child ever had or currently have seizures or epilepsy? Yes No

Are they able to pursue all normal activities? Yes No

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 Record

IMMUNIZATION HISTORY	1st Dose	2nd Dose	3rd Dose	4th Dose	Last Dose
Diphtheria & Tetanus (DTP, DTap, Pertussus, Td) Most recent dose should be within 10 years.					
Polio					
MMR					
Or Measles					
Or Mumps					
Or Rubella					
Hepatitis B					
Haemophilus Influenza B					
Varicella (Chicken Pox)					
Meningococcal Meningitis (optional)					
Other (please specify)					

*OPTIONAL: PROVIDE A COPY OF ANY PRESCRIPTIONS AND MEDICAL/DENTAL INSURANCE CARDS

***NOTE: IN CASE OF EMERGENCY YOU WILL BE ASKED TO PROVIDE A COPY OF THE FRONT AND BACK OF YOUR MOST CURRENT INSURANCE CARD**

Mailing Instructions:

1. Health forms must be postmarked at least 14 days in advance of camper registration. *Later submissions must be hand carried.*
2. Ensure parent signature is completed on front of form.
3. Ensure physician signature is completed on medication form.
4. **Mail to:** Word of Life Camps Health Services
PO Box 600
Schroon Lake, NY 12860-0129

FedEx/UPS to: Word of Life Camps Health Services
4200 Glendale Rd
Pottersville NY 12860

**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. Physician's signature and approval is required.

Medication Order	Dosage	Physician Approval
		Please check Yes or No
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 ___

Parents or guardians please list your child's prescription medications, vitamins, herbs and or dietary supplements, as ordered by the child's physician. Physician's signature is required for 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.

New York State Department of Health

Meningococcal Disease

Last Reviewed: November 2006

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 two to 10 days after exposure, but usually within five days. Among people who develop meningococcal disease, 10 to 15 percent 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, daycare 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 to 55 years of age. The previously licensed version of this vaccine, Menomune™, is available for children two to 10 years old and adults older than 55 years. Both vaccines are 85

to 100 percent effective in preventing the four kinds of the meningococcus germ (types A, C, Y, W-135). These four types cause about 70 percent 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 to 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 three to five 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 Web sites of the New York State Department of Health, www.nyhealth.gov; the Centers for Disease Control and Prevention www.cdc.gov/ncidod/diseases/index.htm; and the American College Health Association, www.acha.org.

Revised: July 2005