**MЕДИЧНА КАРТА**

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| **2016 Health History by Parent** | |
| **1 week Overnight Camp** |  |

**ПРОСИМО ДОКЛАДНО ДРУКОМ ВИПОВНИТИ. PLEASE PRINT CLEARLY.**

(This side to be filled by parents/guardian of minors or by adult campers/staff members themselves.)

**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*

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| **Do you carry family medical/hospital insurance?** Yes No ***PLEASE ATTACH FRONT AND BACK COPY OF INSURANCE CARD***  **If NO, please fill out “No Insurance Form” and send in with application paperwork.** |

Operations or serious injuries *(dates)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Name of dentist/orthodontist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of family physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of family physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suggestions on health related information for camp personnel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Female:** Has this person menstruated? \_\_\_\_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **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 MenactraTM and MenveoTM. 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 a](http://www.meningitisvaccine.com/)nd the website of the Center for Disease Control and Prevention (CDC), [www.cdc.gov/vaccines/vpd-vac/mening/default.htm;](http://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 MenactraTM or MenveoTM.  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. |

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’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Health History by Licensed Physician

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# \*\*\*DOCTOR: PLEASE ATTACH IMMUNIZATION HISTORY \*\*\*

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| **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: PLEAS*** | ***E*** |  | **DRUG NAME/ROUTE** |  | ***DOCTOR: PLEAS*** | ***E*** |
| ***MEDS BELOW*** | ***MEDS BELOW*** |
| ***CAMPER MAY RECEIVE*** | | | ***CAMPER MAY RECEIVE*** | | |
| **Loratidine PO** |  | | |  | **Anti-fungal ointment TOPICAL** |  | | |
| **Cetirizine HCL PO** |  | | |  | **Antacid/Antigas PO** |  | | |
| **Benadryl PO** |  | | |  | **Stool Softener PO** |  | | |
| **Regular/Junior Strength Acetaminophen PO** |  | | |  | **Tums chewable PO** |  | | |
| **Regular/Children’s Ibuprofen PO** |  | | |  | **Midol PO** |  | | |
| **Cough Medicine PO** |  | | |  | **Throat Spray/lozenges PO** |  | | |
| **Cold & Sinus PO** |  | | |  | **Pepto Bismol** |  | | |

### Camper may not have the following medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIPTION MEDICATIONS *Allergy to Meds:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DRUG NAME** | **ROUTE** | **DOSAGE** | **INDICATIONS** | **COMMENTS** |
|  |  |  |  |  |
|  |  |  |  |  |
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*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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street & Number City State ZIP Area/Number*

Date of Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please initial if completed by nurse or PA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_