



# ВОВЧА ТРОПА

Plast Camp

Sayre Hill Road, East Chatham, New York 12060 (518) 392-5801

## МЕДИЧНА КАРТА HEALTH HISTORY FORM

ПРОСИМО ДОКЛАДНО ДРУКОМ ВИПОВНИТИ.  
PLEASE PRINT CLEARLY.

<input type="checkbox"/> N-chok	<input type="checkbox"/> N-kiv
<input type="checkbox"/> U-chok	<input type="checkbox"/> U-kiv
<input type="checkbox"/> U2	<input type="checkbox"/> Bulava

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

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
*Last First Initial*

Parent or Guardian (or Spouse) \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
*Area/Number Area/Number*

Second Parent or Guardian or Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
*Street & Number City State ZIP Area/Number*

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
*Area/Number Area/Number*

If not available in an emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
*Street & Number City State ZIP Area/Number Area/Number*

**Do you carry family medical/hospital insurance?**  Yes  No **PLEASE ATTACH COPY OF INSURANCE CARD.**  
 If so, indicate: Carrier \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Carrier Address \_\_\_\_\_  
**If NO, please fill out "No Insurance Form" and send in with application paperwork.**

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

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Current medications – please record on **Medication Form** \_\_\_\_\_

Other diseases \_\_\_\_\_

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

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

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 any reasons you cannot sign this, please contact camp authorities as soon as possible.

# Health Care Recommendations by Licensed Physician

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

The applicant is under the care, of a physician for the following condition(s): \_\_\_\_\_

Camper's Name: \_\_\_\_\_

N-chok    N-kiv    U-chok    U-kiv    U2    Bulava

Current treatment – please record on **Medication Form** \_\_\_\_\_

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?  Yes  No **If yes, please record on Medication Form**

Any medically - prescribed meal plan or dietary restrictions? \_\_\_\_\_

**ALLERGIES: (food, NUTS, drugs, plants, insects, etc.)** \_\_\_\_\_

Activities to be encouraged or limited \_\_\_\_\_

Additional health information \_\_\_\_\_

## Immunization History (Copy of immunization history may be included)

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

**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) \_\_\_\_\_

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria } Pertussis (Whooping Cough) } DPT* } Tetanus } or	1 2 3	1 2
Tetanus } TD* Diphtheria } 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		
Meningococcal Meningitis		
Varicella		

I have examined: (Name of Camper) \_\_\_\_\_ Date Examined \_\_\_\_\_

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 Form Completion \_\_\_\_\_ \*By \_\_\_\_\_

*\*Initial if completed by nurse or physician's assistant* **OTK2012**



# ВОВЧА ТРОПА

## Plast Camp

Sayre Hill Road, East Chatham, New York 12060 (518) 392-5801

Dear Parent,

March 1, 2012

We are 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.

Vovcha Tropa 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 /guardian;
- 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. 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](http://www.meningitisvaccine.com). I encourage you to carefully review the enclosed materials. **Please complete the Meningococcal Vaccination Response Form and return it along with your health forms.** To learn more about meningitis and the vaccine, please 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](http://WWW.HEALTH.STATE.NY.US), and the website of the Center for Disease Control and Prevention (CDC), [WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO](http://WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO).

Sincerely,  
OTK - Vovcha Tropa, Plast Camp

### MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

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.

**You must CHECK ONE BOX, sign below and return this form.**

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.

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*(Parent/Guardian)*

Please indicate child's camp:

N-chok    N-kiv    U-chok    U-kiv    U2    Bulava



# БОБЧА ТРОФИЯ

Plast Camp

Sayre Hill Road, East Chatham, New York 12060 (518) 392-5801

Individualized Orders for:

Camper's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

N-chok  N-kiv  U-chok  U-kiv  U2  Bulava

## 2012 MEDICATION FORM *as required by Columbia County, NY Dept. of Health*

Physician's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address: \_\_\_\_\_ License # \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ Date \_\_\_\_\_

**STANDARD OVER THE COUNTER/PRN MEDICATIONS:** (The following medications may be available in the infirmary and will be administered at the discretion of the RN, **ONLY IF approval is indicated with a check mark below by the camper's physician**).

DRUG NAME/ ROUTE	INDICATIONS	PLEASE CHECK MEDS CAMPER MAY RECEIVE	OTHER INDICATIONS	DRUG NAME/ ROUTE	INDICATIONS	PLEASE CHECK MEDS CAMPER MAY RECEIVE	OTHER INDICATIONS
Advil Cold & Sinus PO	As directed on packaging			Imodium AD PO	As directed on packaging		
Bacitracin ointment TOPICAL	As directed on packaging			Junior Strength Tylenol PO	As directed on packaging		
Benadryl (caps. & elixir) PO	As directed on packaging			Maalox Tabs & Liquid PO	As directed on packaging		
Burn Jel TOPICAL	As directed on packaging			Milk of Magnesia PO	As directed on packaging		
Caladryl Lotion TOPICAL	As directed on packaging			Pepto Bismol (tabs & liquid) PO	As directed on packaging		
Chloroseptic Throat Spray PO	As directed on packaging			Refresh Eye Drops OPHTHALMIC	As directed on packaging		
Children's Advil Suspension &/or chewable - PO	As directed on packaging			Regular Strength Tylenol PO	As directed on packaging		
Child. PediaCare Nightrest PO	As directed on packaging			Robitussin CF PO	As directed on packaging		
Children's Tylenol suspension &/or chewable - PO	As directed on packaging			Triaminic Cold & Cough PO	As directed on packaging		
Claritin PO	As directed on packaging			Tylenol Allergy Sinus PO	As directed on packaging		
Dimetapp Cold & Allergy PO	As directed on packaging			Tylenol Sinus PO	As directed on packaging		
Eye irrigating solution OPHTHALMIC	As directed on packaging			Tylenol Sore Throat PO	As directed on packaging		
Hydrocortisone Cream 1% TOPICAL	As directed on packaging			Vicks Nyquil PO	As directed on packaging		
Ibuprofen PO	As directed on packaging			Midal PO	As directed on packaging		

## PRESCRIPTION MEDICATIONS:

DRUG NAME	ROUTE	DOSAGE	INDICATIONS	COMMENTS