



# Children's Camper Health History/Physical Exam Form

**FILL IN ALL REQUESTED INFORMATION OR ENCLOSE A COPY OF PHYSICAL AND IMMUNIZATION RECORDS**

Camper Name \_\_\_\_\_

**Physical Examination** - To be filled out by a licensed provider (i.e. MD, PA or NP).

*New York State law requires a signed/dated physical exam, within the last 12 months and dates of most current boosters*

**Immunization History - MUST BE COMPLETED WITH DATES OR ENCLOSE A COPY.** Please record the date (month and year) of basic immunizations and most recent booster doses:

DPT or DT     Tuberculosis     COVID Vaccine     Hepatitis vaccination     Chicken Pox Vaccine  
 MMR     Polio vaccine (most recent)     Pneumonia vaccination     Recent exposure to contagious disease     Flu vaccine

**General Condition or Appraisal – Complete if physical not included\***

Birthdate _____	Nutrition _____	Allergy _____	Athlete's foot _____
Height _____	Nose _____	Foods _____	Impetigo _____
Weight _____	Throat-tonsils _____	Drugs _____	Infection _____
Posture & Spine _____	Lungs _____	Other _____	Pediculosis _____
Feet _____	Eyes _____	Abdomen _____	Describe Current conditions (diabetic, seizures, emotional issues, etc.) _____
Teeth _____	Discharge _____	Genitals _____	
Blood pressure _____	Glasses _____	Hernia _____	
Heart murmur _____	Menstruation _____	Skin _____	_____
Ears _____	Urine _____	Scabies _____	_____

**Standard Over the counter/PRN medications:** (The following medications are available in the infirmary and will be administered at the discretion of an RN, if approval is indicated by the camper's healthcare provider i.e. MD, PA, or NP). The provider must initial each medication approved.

Drug Name	Route (indicate formulation[s])	Dosage	Schedule & Indications	HEALTHCARE PROVIDER INITIALS	Comments
Sunburn Spray/Lotion/Aloe-Gel	Topical	To affected site	2-3 times daily (prn)		
Acetaminophen (Tylenol)	PO (chewable tabs, elixir, tabs)	Per label instr. by age/weight	Q 4 hr prn for pain or fever > _____ °F		
Ibuprofen (Motrin)	PO (chewable tabs, elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for pain or fever > _____ °F		
Diphenhydramine Hydrochloride (Benadryl)	PO (chewable tabs, elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)		
Hydrocortisone Cream or Benadryl Cream	Topical	Per label instr. by age/weight	prn - itching		
Tums	Chewable tab	Per label instr. by age/weight	No > 10 tabs/24 hrs		
Throat Lozenges/Cough Drops	Tab	1 Lozenge	No > 6/24 hr		

**Prescription Medications** (please complete with patient's current regimen for both scheduled and prn medications. Use additional page if needed.)

Drug	Route	Dosage	Schedule & Information	Comments

**Additional Orders** (as deemed necessary by healthcare provider to be implemented by an RN (i.e. peak flows, dressing changes, cast care, etc.). Multivitamins must be included if taking, as well as OTC such as Melatonin.

**I BELIEVE THIS CHILD IS ABLE TO ATTEND CAMP AND PARTICIPATE IN ALL CAMP ACTIVITIES WITH THE FOLLOWING RESTRICTIONS AND RECOMMENDATIONS (ATTACH SPECIFIC INSTRUCTIONS OR MEDICATIONS, TREATMENTS AND DIET, RESTRICTIONS OR CONSIDERATIONS):**

Provider's Name (print) _____	License #: _____
Providers Signature _____	Date: _____
Address: _____	Phone: _____

**\* RN MAY ONLY GIVE THOSE LISTED AND/OR INITIALED! NO EXCEPTIONS.**

# Children's Camper Health History/Physical Exam Form

Fill in all requested information. Incomplete forms cannot be processed and will be returned. Forms are due two (2) weeks before your child's session begins.

Mail to: **Camp Cherokee, c/o New York Conference of SDA, P O Box 15502., Syracuse, NY 13215**

**Please Print (THIS SIDE AND TOP OF BACK PAGE TO BE FILLED IN BY PARENT BEFORE PHYSICAL EXAMINATION).**

Camper Name \_\_\_\_\_ Birth date: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_ Home Address \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business/Cell Phone \_\_\_\_\_  
 Other Parent/Guardian \_\_\_\_\_ Home Address: \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business/Cell Phone \_\_\_\_\_  
 In the event of emergency, and parent or guardian cannot be reached, notify \_\_\_\_\_ Relationship to camper \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Business/Cell Phone \_\_\_\_\_

**Note:**

This person must be a relative over 18. If someone is not a relative, a "notarized statement" authorizing that person to approve medical treatment is necessary. In the event of an injury or illness that does not require removal to a hospital, parents shall not be notified unless medical personnel's concerns dictate. When injuries or illnesses require a trip to the hospital, either the RN accompanying the camper or the camp director or their designee will notify the parents.

**Health History** - To be completed by **PARENT/GUARDIAN** (give approximate date of illness or "no" if not applicable)

<input type="checkbox"/> frequent ear infections	<input type="checkbox"/> hypertension	<input type="checkbox"/> bleeding/clotting	<u>Allergies</u>	<u>Diseases</u>
<input type="checkbox"/> heart defect/disease	<input type="checkbox"/> psychiatric treatment	<input type="checkbox"/> bed wetting	<input type="checkbox"/> hay fever <input type="checkbox"/> other	<input type="checkbox"/> chicken pox
<input type="checkbox"/> diabetes	<input type="checkbox"/> sleep walking	<input type="checkbox"/> fainting	<input type="checkbox"/> plants <input type="checkbox"/> insect stings	<input type="checkbox"/> measles
<input type="checkbox"/> seizures	<input type="checkbox"/> menstrual issues	<input type="checkbox"/> asthma	<input type="checkbox"/> food: _____	<input type="checkbox"/> German measles
			<input type="checkbox"/> animals _____	<input type="checkbox"/> mumps
				<input type="checkbox"/> whooping cough

Medication Allergies/Reaction: \_\_\_\_\_  
 Current medication (send in original container with instructions): \_\_\_\_\_  
 Operations or serious injuries (dates): \_\_\_\_\_ Disability of chronic or recurring illness: \_\_\_\_\_  
 Dietary modifications: \_\_\_\_\_ Any specific activities limited: \_\_\_\_\_  
 Name of dentist/orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical Insurance**

Policy Holder's Name	Name of insurance carrier and type of coverage	Policy No.	Group No.
Authorization for release for information to above named insurance carrier			
Signature _____ Date _____ Relationship to camper (parent, etc.) _____			
Address of Insurance Company _____			

Your personal medical policy is your child's primary coverage. All campers must have medical insurance to attend camp. All registered campers are covered by excess coverage accident insurance while at camp.

**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 prescribed 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 test, treatment and necessary transportation for 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 my child, as named above. The completed forms may be photocopied for trips out of 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 for every camper who attends camp for seven (7) or more nights. Please 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. Re-vaccination may be considered within 3-5 years)

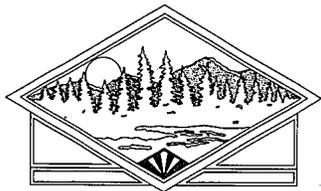
I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signature of parent or guardian \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor \_\_\_\_\_

Licensed physician to fill out back of this form



# CAMP CHEROKEE

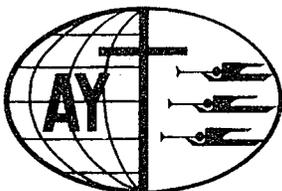
"Changing Lives - Making Memories"

## Summer Camp:

433 Gilpin Bay Road  
Saranac Lake, NY 12983  
Phone: (518) 891-3520  
Fax: (518) 897-2134

## Syracuse Headquarters:

Phone: (315) 469-6921  
Fax: (315) 469-6924



New York Conference  
of Seventh-day Adventists  
Youth Ministries

4930 W. Seneca Turnpike  
Syracuse, N.Y. 13215

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Health Law (NYS PHL) §2167 and Subpart 7-2 of the State Sanitary Code requires overnight children's camps to distribute information about meningococcal disease and vaccination to all campers who attend camp for 7 or more consecutive nights.

Camp Cherokee is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal disease and vaccine information signed by the camper's parent or guardian; AND EITHER
- A record of meningococcal meningitis immunization OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,00-1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotic, 10-15% of these people die. Of those who live, another 11-19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16-21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (MCV4) is the preferred vaccine for people 55 years of age and younger. For example, 2 MCV4 vaccines are Menactra™ and Menveo™.

The Centers for Disease Control and Prevention recommend two doses of MCV4 for all adolescents 11 through 18 years of age: the first does at 11 or 12 years of age, with a booster does at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16<sup>th</sup> birthday, a booster is not needed.

- Meningococcal polysaccharide vaccine (**MPSV4**) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55. The trade name of MPSV4 is Menomune.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

To learn more about meningitis and vaccine, please feel free to contact your child's physician. You can also find information about the disease a the website of the Center for Disease Control and prevention: [www.cdc.gov/vaccines/vpd-vac/mening/default.htm](http://www.cdc.gov/vaccines/vpd-vac/mening/default.htm).

Sincerely,

A handwritten signature in cursive script that reads "Dan Whitlow".

Dan Whitlow  
Director