VISITING STUDENTS & SUMMER CAMP PROGRAM
327 Route 21C, Ghent, NY 12075 (518)672-4790 FAX (518)672-7608
Web:www.vspcamp.com **E-mail: vsp@taconic.net**

PHYSICAL EXAMINATION FORM **Completed by Licensed Medical Personal**

Dates will attend camp: from_________to __________ Age on arrival at camp: ________________________
Camper Name:_______________________________________Male ____Female____DOB: ______________________
Camper home address____City, State,Zip___________________________
Custodialparent(s)/guardian(s)name____
phone:____ cell #____

Exam Date: _______ **Weight:**_____**lbs.** **Height:**_______ **Blood Pressure**_____/____
Allergies: ___**none known**
Allergies _____**To medications** list below**;To environment** (insects, hay, animals?) list below;**Foods** list below**Other***
***List allergies & describe previous reactions** **Bring your own EPIPEN ! if needed**

Medical provider, please, cross out those items CAMPER SHOULD NOT be given. These will be available through the nurse at the camp infirmary and used on an as-needed basis to manage illness and injury.

Meds		Remedies/Supplements		
Ibuprofen	Acetaminophen	Activated Charcoal	cough syrup & lozenge	Arnica 6 x
Calamine Lotion	Benadryl	Apis mell. 6x	Nux vomica 30 x	Echinaceae

Please provide a copy of immunization records or fill out IMMUNIZATION History on page 2.
The camper is undergoing treatment at this time, for the following conditions:

____

Medication camper will take while at camp:
Please, include any homeopathic remedies or supplements including OTC.

Name of Meds	Dose	Frequency

Other treatments/therapies to be continued at camp: ____none; ___yes, describe:

____

Does the camper require limitations or restrictions to activities at camp? ___no ____yes, describe:

"It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above)."
Name of licensed provider:___________________________________Signature:_________________________________
Address :____
Telephone no.:____ Date:_________________________________

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HEALTH HISTORY FORM **Completed by Licensed Medical Personnel* And Parent****

**Camper Name:____DOB___________________________________

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name:_______________________________________ Relationship to camper:____________________________
Phone#:_______________________________________ Cell phone#:____________________________________
Home Address:____
____
Additional contact in event parents/guardians can not be reached:
Name:____ Relationship to Camper:__________________________
Phone#:____ Cell phone#:__________________________________

***Diet/Nutrition**: ___this camper eats a regular diet; ___**explain special dietary needs on page 4.**

*IMMUNIZATION History – Attach immunization records from Health Care Provider or complete below:

****If camper IS NOT immunized attach a signed parent's statement stating the reason for the exemption to this form.**

*Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	most recent dose
	date	date	date	date	date	date
Diptheria,Tetanus,						
Pertussis						
Tetanus Booster						
Measles,Mumps,Rubella						
Polio(IPV)						
Hepatitis B						
Varicella						
Meningococcal Meningitis MCV4						

****Yes, I have received and read the information regarding meningococcal meningitis disease. ______ (initial) I have decided not to obtain immunization against that disease (only for a child over 12 years of age)_____(initial)**

*Which of the following has the camper had? ___Measles; ___Chicken pox; ____German Measles; ___Mumps; ___Hepatitis A; ___Hepatitis B; ___Hepatitis C

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PARENT QUESTIONS/INSURANCE/PERMISSION Completed by Parent

Camper Name:_____________________________________DOB______________________

Has/does the participant:

1. had any recent injury, illness, Infectious disease ?__________________
2. have a chronic or recurring Illness? ____________________________
3. ever had surgery ?____________________
4. ever had a head injury ?_______________
5. have frequent headaches?______________
6. wear glasses, contacts ?_______________
7. ever passed out during or after exercise ?______________________
8. have problems with sleepwalking?_______
9. ever had seizures ?__________________
10. ever been diagnosed with heart murmur ?______________________________
11. have an orthodontic appliance being brought to camp?_____________________________
12. have any skin problems?_________________________
13. have diabetes ?_________________________________
14. have asthma ?__________________________________
15. had mononucleosis in past 12 months?_____________________________________
16. have a history of bed wetting?_____________________
17. treated for ADD or ADHD or similar symptoms?______
18. ever been treated for eating disorder?________________
19. difficulties during menses ?_______________________

(Use separate sheet for details.)

Medical Insurance Information

All medical expenses originating from doctor's visits/ER visits are the responsibility of the parent/guardian of the camper. Please, provide health insurance information. The medical provider will bill the parent's insurance directly.

This camper is covered by family medical/hospital insurance ___yes; ___no;
Include a copy of your insurance card if appropriate; copy both sides of the card.

Insurance Company:____Policy No.:________________________

Subscriber:____Relationship to Participant.:___________________
Carrier Address: ____
Insurance Company Phone #___________________________________

Permission for Providing Treatment for Emergency Care/Activities/Photos

My/Our child has permission to engage in all activities including supervised swimming and incidental immersion (wading through streams) at off campus sites during camp unless otherwise noted by the physician or by me._______(initial)

In the **event of an emergency** I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give permission to the physician to hospitalize and secure proper treatment for my child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. The camp-director or camp-nurse have permission to contact the child's health care providers and these providers may talk with them about my child's health status in an acute situation.

____
Signature of custodial parent/guardian   Date

I give permission to use photos of my child for camp publicity purpose: yes_____, no______.

Dietary Needs

Camper name:_________________________________

Camp dates:___________________________________

Birthday during camp?__________when?______________

Please check

No dietary restrictions ___
Vegetarian ___
Vegan ___

Food Allergies? please, list foods and reactions below

____
____
____
____

Other Allergies? Please list item and reactions:

____
____
____
____
____
____

ALLERGIC TO BEE STINGS? NO____ Yes______ List Reactions
(Bring Epi pen to camp)

____
____
____
____

One copy to go to the Dining hall manager

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Dear Parents: February 2009

I am writing to inform you about a new law in New York State which became effective on August 15, 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 camp is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information (enclosed) initialed by the camper's parent or guardian; AND
- 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 initialed by the camper's parent or guardian.

PLEASE: Initial the appropriate box on the HEALTH HISTORY FORM to show that you have read the enclosed information.

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.

-Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

-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. Our Summer Camp Program does not offer the vaccine.

I encourage you to carefully review the information provided by The National Vaccine Information website at WWW.NVIC.ORG, or call (703) 938-0342 and the enclosed material in order to make an informed decision about your choices on this issue. We do not require your child to receive this immunization in order to attend our camp but we must have on file your initial stating that you read the information and/or decided not to obtain this vaccine. Please see the **Health History Form** to indicate your response.

To learn more about meningitis and the vaccine, please feel free to contact 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, and the website of the Center for Disease Control and Prevention (CDC): WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO.

Sincerely, Nick Franceschelli, Camp Director

New York State Department Of Health: Bureau of Communicable Disease Control

Meningococcal Disease

Information for College Students and Parents of Children at Residential Schools and Overnight Camps

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).

Who gets meningococcal disease?

Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. **Currently**, **no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease.** However, these children can be in settings similar to college freshmen living in dormitories. Other persons at increased risk include household contacts of a person known to have had this disease, and people traveling to parts of the world where meningitis is prevalent.

How is the germ meningococcus spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. 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.

How soon do the symptoms appear?

The symptoms may appear 2 to 10 days after exposure, but usually within 5 days.

What is the treatment for meningococcal disease?

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

Is there a vaccine to prevent meningococcal meningitis?

Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States. The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to 2 days. After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

How do I get more information about meningococcal disease and vaccination?

Contact your family physician or your student health service. Additional information is also available on the National Vaccine Information website at www.nvic.org , phone (703) 938-0342, and the websites of the New York State Department of Health, www.health.state.ny.us; the Centers for Disease Control and Prevention www.cdc.gov/ncid/dbmd/diseaseinfo; and the American College Health Association, www.acha.org.

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