Word of Life Fellowship
Reaching Youth With the Gospel of Christ

Word of Life Camp Health Services wants to provide your child the best care possible within the laws and guidelines of New York State. Please fill out these forms carefully as they are legal documents and are necessary for your camper to enter camp. More importantly, they will allow us to care for your camper properly and within the directions provided by you and their health care professionals.

HEALTH CENTER CHECKLIST

- ☐ Health Forms Filled out and sent in (pages 1-4)
  - ☐ Meningococcal Meningitis Vaccine Response page 1
  - ☐ Parent signature pages 1 and 4
  - ☐ Provider signature on medication form (if applicable)
  - ☐ Immunization Record attached / filled in
  - ☐ Copy of Insurance Card attached (if applicable)
  - ☐ Copy of forms sent (2 weeks in advance) by
    fax (preferred): 518-494-1487
    e-mail: healthcenter@wol.org
    post: WOL Health Center; PO BOX 600; Schroon Lake, NY 12870
  - ☐ Original form brought to registration
- ☐ Medications prepared for camp (if applicable)
  - ☐ Every item on page 4 list B is packed
  - ☐ Only items on page 4 list B are packed
  - ☐ All medications are in original containers
  - ☐ No medications are expired
- ☐ Camper in good health
  - ☐ No recent illness (fever, vomiting, diarrhea)
  - ☐ No head lice or nits
- ☐ Questions?
  - ☐ Call the Health Center 518-494-1600
  - ☐ E-mail us: healthcenter@wol.org

2014 Word of Life Health and Activity Record

For Office Use Only: Group # _____ ☐ Reviewed ☐ Scanned

Word of Life Fellowship
Reaching Youth with the Gospel of Christ

Camper Information

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

Name:_____ Dates Attending Camp:_____
LAST FIRST MIDDLE

Gender: ☐ Male ☐ Female Date of Birth: _____ ☐ Island ☐ Ranch/Ranger

Parent / Guardian Information

☐ Parent ☐ Guardian Name:_____ Primary Phone #: _____
LAST FIRST

Address:_____ Secondary Phone #: _____
CITY STATE ZIP

Emergency Contact Information

Name:_____ Relationship to Camper:_____
LAST FIRST

Primary Phone #: _____ Secondary Phone #: _____ Alternate Phone #: _____

Group Information

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

Name of Church / Group:_____ Group Leader:_____

Church/Group Address:_____ Leader Cell: _____

Leader accommodation and accommodation phone number:_____

Meningococcal Meningitis Vaccination Response – please check one

☐ I have (my child has) had the meningococcal meningitis immunization within the past 10 years. Please provide documentation in immunization record section.

☐ I have (my child has) read, or have had explained to me information regarding meningococcal meningitis disease (attached). I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease. Check here if child not old enough to receive vaccine (first dose recommended age 11-12).

Sunscreen – please check one

☐ My child has my permission to carry and use sunscreen at camp.

☐ My child does not have my permission to use sunscreen.

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 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. I understand that I am financially responsible for all medical cost(s) incurred while my child is at camp. This form may be photocopied for use out of camp.

Signature:_____ Date:_____
(PARENT/GUARDIAN IF CAMPER IS A MINOR)

Print Name:_____

Insurance Information

Do you have Health Insurance? ☐ Yes ☐ No

If you do not have insurance please provide the following information:

Person financially responsible for medical costs:_____

Contact Number for person financially responsible: _____

If you do have insurance, please provide a copy of your card AND fill out requested information below:

Copy of Front Side

Copy of Back Side

Insurance Subscriber's Name: _____

Insurance Subscriber's Date of Birth: _____

Do you have a co-pay associated with your insurance? ☐ Yes ☐ No If yes, how do you plan to cover that cost?

_____

Confidential Personal Health History Report

ALLERGIES ☐ Food ☐ Medication ☐ Environmental

What is the allergen, the reaction to it, and management or treatment of the reaction:

MEDICAL / SURGICAL HISTORY

☐ Yes ☐ No Asthma / wheezing
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Seizure disorder
☐ Yes ☐ No History of bedwetting
☐ Yes ☐ No Back / joint problems
☐ Yes ☐ No Fainting or dizziness
☐ Yes ☐ No Passed out / chest pain during exercise
☐ Yes ☐ No Mononucleosis during past 12 months

☐ Yes ☐ No Recent injury
☐ Yes ☐ No Surgery or hospitalization
☐ Yes ☐ No Recurrent/chronic illnesses
☐ Yes ☐ No Recent infectious disease
☐ Yes ☐ No Frequent headaches
☐ Yes ☐ No Glasses / contacts / protective eyewear
☐ Yes ☐ No ADD / ADHD
☐ Yes ☐ No Mental / Emotional Treatment
☐ Yes ☐ No Activity Restrictions

Please explain any yes answers:

HEALTH CARE PROVIDERS

Name of Primary Care Provider: _____ Phone: _____

Name of Dentist or Orthodontist: _____ Phone: _____

IMMUNIZATIONS

Has your child received any immunizations? ☐ Yes ☐ No
Does your child have a religious or medical waiver? ☐ Yes ☐ No
Please fill in all immunizations below OR attach copy of immunization record and / or waiver

Immunization Record

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

Medications

Please choose one:

□ I do NOT want my child to receive any medications while at camp, and they will not bring any. (Please understand that the nurse will not be able to give any medication to your child).

Parent / Guardian Signature_____ Date_____

□ I want my child to receive, or have the option to receive, medications at camp. **This form must be filled out and signed by a licensed health care provider authorized to prescribe medications.** Parent / guardian must sign as well, after form has been completed and signed by provider.

INDIVIDUALIZED MEDICATION ORDERS

A) MEDICATIONS AVAILABLE AT CAMP – YOU DO NOT NEED TO BRING THESE

Drug Name	Route	Dosage	Schedule	Provider order
Acetaminophen (Tylenol)	PO	Per label instructions by age/wt	as needed for pain or fever	□ yes □ no
Ibuprofen (Advil, Motrin)	PO	Per label instructions by age/wt	as needed for pain or fever	□ yes □ no
Diphenhydramine(Benadryl)	PO	Per label instructions by age/wt	as needed for allergies or itching	□ yes □ no
Hydrocortisone cream 1%	topical	Per label instructions by age/wt	as needed for rash or itching	□ yes □ no
Guaifenesin (Mucinex)	PO	Per label instructions by age/wt	as needed for chest congestion	□ yes □ no
Dextromethorphan (Delsym)	PO	Per label instructions by age/wt	as needed for cough	□ yes □ no
Phenylephrine(decongestant)	PO	Per label instructions by age/wt	as needed for congestion	□ yes □ no
Calcium Carbonate (Tums)	PO	Per label instructions by age/wt	as needed for stomach upset	□ yes □ no

B) OTHER MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, HERBS, SUPPLEMENTS) – MUST BRING EVERYTHING LISTED BELOW

Drug Name	Route	Dosage	Frequency and Indications	Comments

(Attach additional sheet if necessary. Must be signed by provider as well)

Physician Name (print)_____

Signature:_____

Date: _____

Provider Contact Information / Stamp

I agree that my child will bring everything listed in section B above. I have checked the form to ensure that the medications and directions are accurate and complete.

Parent / Guardian Signature_____ Date_____

Meningococcal Disease

New York State Department of Health Bureau of Communicable Disease Control

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, immunocompromised people, 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.

Is the vaccine safe? Are there adverse side effects to the vaccine?

- The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

What is the duration of protection from the vaccine?

- 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 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.