girl scouts of nassau county

Girl Scouts of Nassau County
Camp Blue Bay
Health Form Instructions

The following items and/or sections NEED to be filled out on the Camp Blue Bay Health Form in order for it to be considered complete:

- **Emergency contact information** (a person other than a parent) (**found on 1st page of Camp Blue Bay Health Form*)
- **Parent/guardian signature** (*found on page 1 of Camp Blue Bay Health Form*)
- **Complete Immunization record (***found on page 3* of *Camp Blue Bay Health Form).* Please note writing in "up to date" is NOT acceptable. Immunization record can be filled in on our form ***or*** attached as a separate print out or photocopy from your doctor.
- **Date of child's last physical examination (***found on page 4 of Camp Blue Bay Health Form)* ***(Suffolk County Board of Health requirements specify that exams must have taken place within 12 months of exact date of camp attendance. A new exam is not necessary for camp attendance if you have had one within 12 months.)***
- **Doctor's original signature with 2014 date** (*found on page 4 of Camp Blue Bay Health Form).*

***Please note, we cannot accept a photocopy or faxed copy of a doctor's signature. (Your child does not necessarily need to have another physical, but we **do** need an **original** signature)*

- **Meningococcal/Meningitis Response Form (A parent/guardian needs to sign the Meningococcal/Meningitis Response Form *whether or not* your child has received the meningitis vaccination.)** We do NOT REQUIRE your child to get this vaccination but we DO need the signed Meningitis Form, for your child to be able to attend camp.
- **The Standing Order for Over the Counter Medications**
  While the Standing Orders Form for over the counter medications is not required, we STRONGLY URGE YOU to have this filled out by your doctor. If a signed form is not available at camp, the camp nurse will be unable to administer any medication to your child. This would include such medications as Tylenol, Benadryl or Tums. **Phone authorizations cannot be accepted**.

Camp Blue Bay Health Form 2014

By June 1, 2014 Mail this completed form to
Girl Scouts of Nassau County
110 Ring Road West
Garden City, NY 11530

Dates of Camp Attendance_____

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history, (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health exam (last page) must be completed by approved licensed medical personnel at least every two years.

Name_____Birth Date_____Age at camp_____
Last First Middle

Home address_____
Street Address City State Zip

Social Security number (staff only) _____ Gender: _____Male _____Female

Custodial parent/guardian:_____Phone_____

Home Address_____
(*if different from above) Street Address City State Zip*

Company Name_____Phone_____

Second parent or guardian (optional)_____

Address_____Phone_____
Street Address City State Zip

Company Name_____Phone_____

Emergency contact (if parents/guardians not available)_____Relationship_____

Address_____Phone_____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ___Yes ___No

If so, indicate carrier or plan name_____Group #_____

****Photocopy of front and back of health insurance card must be attached to this form.**

IMPORTANT—THESE BOXES MUST BE COMPLETE FOR ATTENDANCE*

This health history form is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purchases.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal Representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I herby give permission to the physician selected by the camp 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 staffer_____

Printed Name_____Date_____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult staffer_____Date_____

**If for any religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

Health History

The following information must be filled in by the parent/guardian or adult staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____
_____ _____
_____ _____
_____ _____

Food allergies (list)

_____ _____
_____ _____
_____ _____

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

_____ _____
_____ _____
_____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

___This person takes NO medications on a routine basis.

___This person takes medications as follows:

Med #1_____Dosage_____Specific times taken each day_____

Reason for taking_____

Med #2_____Dosage_____Specific times taken each day_____

Reason for taking_____

Med #3_____Dosage_____Specific times taken each day_____

Reason for taking_____

Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer:_____
_____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

___Does not eat red meat ___Does not eat pork ___Does not eat eggs
___Does not eat poultry ___Does not eat seafood ___Does not eat dairy products
___Other (describe)_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____
_____

General Questions (Explain "yes" answers below.)

Please explain any "yes" answers, noting the number of the questions.

Has/does the participant: (Please circle answer)

1.	Had any recent injury, illness or infectious disease?	YES	NO
2.	Have a chronic or recurring illness/condition?	YES	NO
3.	Ever been hospitalized?	YES	NO
4.	Ever had surgery?	YES	NO
5.	Have frequent headaches?	YES	NO
6.	Ever had a head injury?	YES	NO
7.	Ever been knocked unconscious?	YES	NO
8.	Wear glasses, contacts or protective eye wear?	YES	NO
9.	Ever had frequent ear infections?	YES	NO
10.	Ever passed out during or after exercise?	YES	NO
11.	Ever been dizzy during or after exercise?	YES	NO
12.	Ever had seizures?	YES	NO
13.	Ever had chest pain during or after exercise?	YES	NO
14.	Ever had high blood pressure?	YES	NO
15.	Ever been diagnosed with a heart murmur?	YES	NO
16.	Ever had back problems?	YES	NO
17.	Ever had problems with joints (e.g., knees, ankles)?	YES	NO
18.	Have an orthodontic appliance being brought to camp?	YES	NO
19.	Have any skin problems (e.g., itching, rash, acne)?	YES	NO
20.	Have diabetes?	YES	NO
21.	Have asthma?	YES	NO
22.	Had mononucleosis in the past 12 months?	YES	NO
23.	Had problems with diarrhea/constipation?	YES	NO
24.	Have problems with sleepwalking?	YES	NO
25.	If female, have an abnormal menstrual history?	YES	NO
26.	Have a history of bed-wetting?	YES	NO
27.	Ever had an eating disorder?	YES	NO
28.	Ever had emotional difficulties for which professional help was sought?	YES	NO

_____
_____
_____
_____
_____

Which of the following has the participant had?

___Measles
___Chicken pox
___German measles
___Mumps
___Hepatitis A
___Hepatitis B
___Hepatitis C

TB Mantoux Test
Date of last test_____

Result: ___Positive
___Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____				
Or Measles	_____	_____				
Or Mumps	_____	_____				
Or Rubella	_____	_____				
Haemophilus Influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				
Menomune/Menactra	_____	_____				

Use this space to provide any additional information about the participants behavior and physical, emotional, or mental health of which the camp should be aware.

_____
_____
_____
_____
_____
_____

Name of family physician_____Phone_____

Address_____

Name of family dentist/orthodontist_____Phone_____

Address_____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____(**DATE**)_. ***(Suffolk County Board of Health requirements specify that exams must have taken place within 12 months of exact date of camp attendance. A new exam is not necessary for camp attendance if you have had one within 12 months.)***

BP_____ Weight_____ Height_____

In my opinion, the above applicant ____is ____is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

_____
_____
_____
_____
_____
_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp_____
_____

Medications to be administered at camp (name, dosage, frequency)_____
_____

Any medically-prescribed meal plan or dietary restrictions_____
_____

Known allergies_____
_____

Description of any limitation or restriction on camp activities_____
_____

Additional information for health care staff at the camp_____
_____

ORIGINAL Signature of Licensed Medical Personnel_____

Print Name_____Title_____

Address_____

Phone_____Date_____

Screening record (for camp use only)

Date screened_____Time_____

Meds received_____
_____

Updates/additions to health history noted ____Yes ____No ____None required

Current health needs identified_____
_____

Observational notes_____
_____

Screened by_____

girl scouts of nassau county

GIRL SCOUTS OF NASSAU COUNTY, INC.
110 Ring Road West
Garden City, NY 11530-3296
T 516.741.2550 F 516.741.2207
www.gsnc.org

March 2014

Dear Parent/Guardian

I am writing to inform you about meningococcal disease, a potentially fatal bacteria 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.

Camp Blue Bay 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 or guardian; **AND**
Information on the availability and cost of meningococcal meningitis vaccine (Menomune or Menactra); **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.

Cases of meningitis among teens and adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3000 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.

I encourage you to carefully review the enclosed materials. ***Please complete the Meningococcal Vaccination Response Form and return it along with your child's Health Form no later than June 1, 2014.***

To learn more about meningitis and the vaccine, please 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 www.cdc.gov/ncidod/dbmd/diseaseinfo.

Sincerely,

Laura Bissett-Carr
Manager, Program & Outdoor Services
Girl Scouts of Nassau County

girl scouts of nassau county

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CAMP BLUE BAY
MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

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.

Check one and sign below

_____My child has had the meningococcal meningitis immunization (Menomune, Menactra, etc.) 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.

_____I have read, or have had explained to me, the information regarding meningococcal meningitis disease but my child is not old enough to receive this vaccination.

Signed: _____ Date: _____
(Parent/Guardian)

Camper's Name: _____ Date of Birth _____

Mailing Address: _____

Parent/Guardian's E-mail address (optional): _____

Camp Blue Bay Standing Orders for Over the Counter Medications

Our nurses will not administer any over the counter medications unless this form has been filled out by your health provider

The New York State Department of Health is requiring that summer camps have an individualized set of standing orders for each attending camper. These standing orders specify which over-the-counter medications carried in the Camp Infirmary may be administered to an individual camper and under what conditions. The prescription medication section covers prescription medications and other over-the-counter medications that the camper will bring to camp. Please consult with your family healthcare provider and have him/her complete the form below.

***A physician, physician's assistant, or nurse practitioner must sign standing orders.**

INDIVIDUALIZED ORDERS FOR: NAME:_____

Age:_____**Weight:**_____

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):

Drug Name	**Route** (Please circle preferred formulation(s)	**Dosage**	**Schedule and Indications**	**Camper Health-Care Provider Order**	**Comments**
Tylenol (Acetaminophen)	PO (Chewable tabs, elixir or tabs)	Per Label Instructions by age/weight	Q 4 hr prn for pain Or fever > ___°F	Yes No	
Motrin (Ibuprofen)	PO (Chewable tabs, suspension, or tabs)	Per Label Instructions by age/weight	Q 6 hr prn for pain Or fever >___°F	Yes No	
Robitussin (Guaifenesin)	PO (Syrup)	Per Label Instructions by age/weight	Q 4 hr prn for Cough	Yes No	
Mylanta	PO (Chewable tabs, Liquid)	Per Label Instructions by age/weight	TID-QID prn for Stomach upset	Yes No	
Tums	PO (Chewable Tabs)	Per Label Instructions by age/weight	BID-TID prn for Stomach upset	Yes No	
Dimetapp	PO (Liquid)	Per Label Instructions by age/weight	Q 6-8 hr prn for Nasal congestion/drainage	Yes No	
Benadryl (Diphenhydramine HCL)	PO (Elixir or tabs)	Per Label Instructions by age/weight	Q 4-6 hr prn for Allergy	Yes No	
Midol	PO (Chewable tabs)	Per Label Instructions by age/weight	Q 4-6 hr prn for menstrual symptoms	Yes No	
Imodium AD (Loperamide)	PO (Tabs)	Per Label Instructions by age/weight	1 caplet after 1st BM, and ½ caplet after each subsequent loose BM	Yes No	
Sudafed (Pseudo ephedrine)	PO (Tabs)	Per Label Instructions by age/weight	Q 4-6 hr prn for nasal decongestant	Yes No	

Camper's Health Care Provider Name:_____Phone #:_____

Address:_____

License #:_____

DOCTOR Signature:_____Date:_____