



**Health History and Examination Form  
for Children, Youth and Adults attending and staffing  
2009 Summer Camps of the Ukrainian American Youth Association, Inc.**

**THIS FORM MUST BE RECEIVED AT THE CAMP OFFICES NO LATER THAN 15 DAYS BEFORE THE FIRST DAY OF CAMP.** Meningitis response and health history must be filled out by parents/guardians of camp or staff applicants. Update is required annually. Health exam must be completed and form must be signed by a licensed physician (on page 2). 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 all your needs.

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First M.I. mm dd yy

Home address \_\_\_\_\_  
Street address City State Zip

Social Security Number of participant \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian(s) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street address City State Zip

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Street address City State Zip

If not available in emergency, notify \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Street address City State Zip

Name of Family Physician \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Street address City State Zip

**Insurance Information:** Is the participant covered by family medical/hospital insurance?  Yes  No

If so, indicate carrier/plan name \_\_\_\_\_ Group# \_\_\_\_\_

**Two photocopies of front and back of health insurance card must be submitted with camp registration forms.**

**Important – these boxes must be completed for attendance at camp**

<p>This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.</p> <p>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 purposes.</p> <p>It is my intention that the camp be treated as acting <i>in loco parentis</i> if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal</p>	<p>representatives" for the purposes 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) to provide relevant information to the camp representatives to keep me informed of my child's health status.</p> <p>In the event I cannot be reached in an emergency, I hereby 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.</p>
Signature of parent or guardian or adult camper/staffer _____	
Printed Name _____ Date _____	

I also understand and agree to abide by any restrictions placed on my participation in camp activities.	
Minor's signature _____	Date _____

**Meningococcal Meningitis Vaccination Response:** A completed response for every camper who attends camp for seven or more nights, is required to be maintained at the camp, pursuant to New York State Public Health Law § 2167.

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.

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First M.I. mm dd yy

**Health History** ALLERGIES - List all known, and describe reaction and management of the reaction.

Medication allergies: \_\_\_\_\_

Food allergies: \_\_\_\_\_

Other allergies (incl. insect stings, hay fever, asthma, animal dander, etc.): \_\_\_\_\_

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

**Immunization History**

Please give all dates of immunization for:

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

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	_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

**Health Care Recommendations by Licensed Physician**

I have examined the above-named individual within the past eighteen (18) months, on \_\_\_\_\_  
 BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the individual  IS  IS NOT able to participate in an active camp program.

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

Current treatment: \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion or concussion: \_\_\_\_\_

**Recommendations and Restrictions at Camp:** Please describe any treatment to be continued at camp, medications to be administered at camp, any medically-prescribed meal plan or dietary restrictions, known allergies, any limitation or restriction on camp activities, and/or additional information for health care staff at the camp.

<b>Signature of Licensed Physician</b> _____	
Printed _____	
Address _____	
Phone _____	Date completed _____
Fax _____	Completed by _____

# 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](http://www.health.state.ny.us); the Centers for Disease Control and Prevention [www.cdc.gov/ncid/dbmd/diseaseinfo](http://www.cdc.gov/ncid/dbmd/diseaseinfo); and the American College Health Association, [www.acha.org](http://www.acha.org).