St Andrews Camp & Retreat Center

1280 State Route 49, Cleveland, NY 13042 (315) 675-9771 saintandrewscamp@aol.com

CAMPER Medical Evaluation

Dear Campers, Parents, Guardians, and Friends:

When we think of resident camping, we should think of fun and excitement, yet even more importantly, at St. Andrews Camp, health and safety are always our top priority. In order to facilitate a more positive stay at St Andrews, we need to have **updated** and **accurate** health information for your camper. Please **sign all forms,** have your child's **health care provider complete and sign them where necessary (three separate places),** and return them to the Office before your camper's arrival. Timely and full completion of these items will greatly expedite your check-in upon arrival at Camp.

It is very important to be thorough when completing these forms. Knowledge of allergies, recent injuries, immunization records, and any other special circumstance will assist the Camp staff in providing an optimal experience for your camper. (It is also a NYS Health Dept. requirement). You should attach a copy of the camper's immunization record.

1. Treatment of Injuries and Illnesses

Wounds are cleaned with soap and/or peroxide, and a sterile dressing with Neosporin (or the equivalent) is applied. All injuries are treated according to the American Red Cross First Aid Handbook, and parents are notified in case of any severe injury. Parents are also notified of any illness experienced by their camper for which symptoms last longer than 24 hours. In case of emergency, all attempts will be made to notify parents (and/or other contacts) immediately.

2. Prescription Medications brought to Camp

Any prescription medications brought to Camp **must** be brought to the Health Director immediately upon registration. No medications, prescription or over-the-counter (OTC), may be kept by participants. **In addition, the attached Individual Orders Form must be completed by each participant's primary health care provider to allow the administration of any medication.** Prescription medications must remain in their original container(s), must clearly state the camper's name, contents, and the health care provider's instructions; and must include the dates of use, name of prescription, dosage amount, and time(s) of day to be administered. The use of medication is closely monitored to protect all campers, and must be stored under lock in the Health Office. Please reclaim it from the Health Director at the close of the camper's session.

3. Over-the-Counter (OTC) Medications

By NY State Law, over-the-counter medications may not be administered to campers without individual written orders by a licensed health care provider. Your child's primary care health care provider must complete the Health care provider's Individual Orders form, to allow Camp health staff to administer them. This form also lists ailments common within camp settings and the OTC medications (or their equivalents) that we use to treat such conditions.

Do not send non-prescription (over-the-counter) medications or supplements with your camper. Their presence in the tent or dorm areas presents a health risk to your camper and others, and is therefore prohibited. Please contact us if clarification is necessary prior to arrival.

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4. Special Diets.

If your child is on a special diet, please notify the Health Director. Special food brought to Camp will be stored in the Kitchen.

Please inform your health care provider that your child will be attending a structured residential camp that requires attending to rules and social cues similar to the school setting, but on a longer day. Since Ritalin is water-soluble and campers will be quite active in the warm outdoors; *your health care provider* may want to adjust the child's dosage while he or she is at Camp to better ensure an enjoyable experience.

5. Insurance Coverage.

Please make sure you have completed the insurance information on page one of the Health Form. **All campers must carry their own medical insurance.** Foreign participants must acquire adequate U.S. medical coverage for their stay in Camp. The camp provides only secondary insurance for accidents

6. Permission to treat and Waiver of Responsibility: ***Must be signed to enable attendance:***

I have read the above information, and give my permission for the staff of St. Andrews Camp to administer treatments according to the Camp's protocols, to my child. In full recognition and appreciation of the dangers and hazards inherent in the camp experience, which I have conveyed to my child, I agree to assume all risks and responsibilities arising out of this activity and any others undertaken as an adjunct thereto; and further, I do for my child, myself, my heirs, and personal representatives hereby release, hold harmless, and forever discharge St. Andrews Camp, its officers, agents, and employees against any and all claims, demands, and actions or causes of action, on account of damage to personal property, or personal injury or death which may result from my child's participation in the camp experience. In addition, I have instructed my child to follow all Camp rules and to seek immediate guidance from Camp counselors and administrators if a serious problem should arise.

In witness whereof, I have caused this release to be executed this **date** _______________________

Parent/Legal Guardian Signature ____

Please Print Name ____

All medical and mental health conditions will be monitored by the nurse. It is the sole discretion of the camp as to whether a camper's condition can be managed at the camp and parents must be prepared to pick up camper whose health needs exceed the capabilities of our staff.

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St. Andrews Camp Confidential Camper Information Form (for Administrative and Cabin Staff)

The staff of St. Andrews cares about your camper, and the following information will help us to better serve her or him. Please take a few moments to prepare your child for and to help us to ensure an optimal camping experience at St. Andrews. Thank you for helping us to meet your goals and expectations.

Campers Name: ___________________________________

- Does your child have any special needs or circumstances that require extra attention? (i.e. physical or mental challenges, learning disabilities, ADD/ADHD, family situations, major life transitions within the past year, etc.)
- Has your child received in-school or out-of-school suspension, or has he/she been assigned to a restrictive placement for behavioral/disciplinary reasons, or been involved in a legal infraction within the past 12 months? If yes to any of the above, please contact the Camp Office. A letter from a school official or medical professional attesting to the appropriateness of the camp program to the child's needs will be required prior to acceptance of the camper's application.
- Are there any behaviors the staff should be aware of; (bed-wetting, sleepwalking, shyness, aggressiveness, eating habits, etc.)?
- The Camp staff will exercise a reasonable amount of discipline to enforce Camp rules. What works best should this be necessary with your child?
- Many campers will experience homesickness early in their session. Short of calling home as our first response, what do you suggest?
- Has your child had a previous overnight stay away from home? Was it a positive experience?
- Are there any recent family situations we should be aware of (i.e. foster situation, custody, major transitions, divorce, births, deaths, etc.)
- Are there any restrictions to be placed on your child's activities?
- Who may pick-up your child? What is her or his relationship to the child? *(Please be prepared to show identification prior to checking-out with the camper.)*
- Who may *not* pick-up your child? Please attach appropriate court documents.
- Use space below and extra sheets if necessary to provide pertinent information suggested above.

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New York State required meningococcal meningitis form.

Camper

Last Name:______________________________ First Name:_____________________________

Date of Birth ______/________ / _______

Parent:

Last Name:_______________________________ First Name:_____________________________

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

MENINGOCOCCAL (One dose within 10 years recommended by NYS PHL §2167)

CHECK ONE (1) BOX ONLY

☐ I have received Quadrivalent polysaccharide vaccine (Menomune™) Date : ______/______ / _____

☐ 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 I (my child) will not obtain immunization against meningococcal meningitis disease.

Signed ____ Date : _____/______ / _______

Meningococcal Disease

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) caused by the meningococcus germ.

Who gets meningococcal disease?
Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first-year college students living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States, approximately 2,500 people are infected and 300 die from the disease. 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 meningococcal meningitis is prevalent.

How is the meningococcus germ spread?

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

What are the symptoms?

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear two to 10 days after exposure, but usually within five days. Among people who develop meningococcal disease, 10 to 15 percent 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.

What is the treatment for meningococcal disease?

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

Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated?

Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, daycare center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (either rifampin, ciprofloxacin or ceftriaxone) from their health care provider. Casual contact as might occur in a regular classroom, office or factory setting is not usually significant enough to cause concern.

Is there a vaccine to prevent meningococcal meningitis?

In February 2005, the CDC recommended a new vaccine, known as Menactra™, for use to prevent meningococcal disease. The previous version of this vaccine, Menomune™, was first available in the United States in 1985. Both vaccines are 85 to 100 percent effective in preventing the four kinds of the meningococcus germ (types A, C, Y, W-135). These four types cause about 70 percent of the disease in the United States. Because the vaccine does not include type B, which accounts for about one-third of cases in adolescents, it does not prevent all cases of meningococcal disease.

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

Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

Who should get the meningococcal vaccine?

The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first-year college students living in dormitories. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers, and travelers to endemic areas of the world. However, the vaccine will benefit all teenagers and young adults in the United States.

What is the duration of protection from the vaccine?

Menomune™, the older vaccine, requires booster doses every three to five years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster doses. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals.

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

Contact your family health care provider or your student health service. Additional information is also available on the Web sites 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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CAMP HEALTH EXAMINATION

To be filled in by parent or adult camper and checked by health care provider at time of examination

Name ____ Birth Date ______ Sex _______ Age ____
(Last) (First) (Initial)

Parent or Guardian (or Spouse)_____________________________Phone (___)____________

Home Address ____
(Street & Number) (City) (State) (Zip)

Emergency Notification:
(1)________________________________ Relationship:____________ Phone:___________

Address: ____Cell Phone:___________ email: _________________

or (2)________________________________ Relationship:____________ Phone:___________

Address: ____Cell Phone:___________ email: _________________

HEALTH HISTORY: (Check if treated with medication)							If camper has an epi-pen please bring It to camp. It will be kept by the Nurse.			
							ALERGIES			
Seizures		Diabetes		Vision Issues			Seasonal Allergies		Penicillin	
Autism		Developmental challenges		Asthma			Insect Stings Bee/Wasp		Latex	
Hearing Issues		Depression		Anxiety			Nuts		Other drugs (name)	
Anemia		Eczema		ADHD			Sulfa			

For females only – onset of menses (Y N)

Operations or Serious Injuries (Dates)____

Disabilities ____

Chronic or Recurring Illnesses____

Regularly Taken Medications (including vitamins or other Over-The –Counter)___________________________
____

NOTE: any meds listed here must be signed off for in the Med. Section of this form

Any specific activities to be
encouraged?____
Restricted?____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable Disease during the three weeks prior to camp attendance.

Suggestions from parents :____

Insurance Information: Ins. Company

Address: ________________________________ Phone __________________

Policy Holder: ____________________________ ID# ______________________

Group # ___________________________

PLEASE ENCLOSE COPY OF INSURANCE CARD

PARENT'S AUTHORIZATION - 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 by me and the examining health care provider. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the health care provider selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.

Signature ____ Date __________________

Health care provider Signature confirming accuracy of above information _________________________________Date______________

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Name:____________________________________

IMMUNIZATION HISTORY

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DTP Series	_____________	Booster	_____________	Tdap or Td Booster	_____________
Polio IPV (Sabin)	_____________	Booster	_____________	Mumps Vaccine (live)	_____________
German Measles (Rubella)	_____________	Measles Vaccine (live)	_____________	Measles / MMR (2nd)	_____________
Hep B (3)	_____________	HIB	_____________	Meningitis	_____________
Hep A	_____________	Hep A (2nd)	_____________	Varicella (2)	_____________

BCG _____________ Last Tuberculin Test Date _____________Results: _______________

X-ray results if PPD is positive _________________________

Other: ____

Other state or municipal examinations required for staff (if any)____

PHYSICAL EXAMINATION - *To be filled out by licensed health care provider*

This examination should be performed within 12 months of arrival at camp.
Examination for some other purpose within this period is acceptable.
Examination is for determining fitness to engage in strenuous activities.

Ht: ___________ Wt: ___________ B.P.: ____________ Resp (R)_______ Pulse (P)_____ Temp (T)_______

CODE: S- Satisfactory N – Not Satisfactory (explain) O – Not Examined

Eyes	__________	Teeth	__________	Spine	__________	Please Specify Alergies
Glasses	__________	Heart	__________	Extremities	__________	____________________________
Ears	__________	Lungs	__________	Skin	__________	____________________________
Nose	__________	Abdomen	__________			____________________________
Throat	__________	Hernia	__________			____________________________

Other (Please Specify)____

General Appraisal: ____

Recommendations and restrictions while in camp.

Special Diet ____

Special Medicine (name it) ____Is parent sending it? ____________________

Swimming, diving ____

Strenuous activity ____

Other ____

____

I have examined the person herein described and I have reviewed his medical history. It is my opinion that he is physically able to engage in camp activities, except as noted above.

Health care provider Signature confirming accuracy of above information ____________________________Date_____________

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Health care provider's Individual Orders for Camp Participant

Must be completed by the participant's health care provider (M.D.) and submitted to the Camp Office *at least two weeks prior to the camper's attendance* at Camp. (Required for all resident camps by the State of NY).

Individual Orders for:

Camper's Name____ Age_____ Weight:______ Lbs / Kg

Standard Over-the-Counter (As Needed) Medications: (The following medications or their generic equivalents are available in the Camp Health Center and will be administered at the discretion of the Camp Health Director, if prior written approval is hereby indicated by the participant's primary health care provider).

OTC drug name (generic equivalents may be used)	Dosage	Route	As Needed Indications	Healthcare Provider Permission?	Comments
Benadryl			Allergies Allergic Reactions	Yes No	
Burn Gel Solarcaine			Burns, Sun Burns	Yes No	
Milk of Magnesia			Constipation	Yes No	
Robitussin			Cough	Yes No	
Imodium AD			Diarrhea	Yes No	
Acetaminophen			Fever, Headache Discomfort	Yes No	
Ibuprofen			Fever, Headache Discomfort	Yes No	
Rubbing Alcohol Caladryl Benadryl Hydrocortisone Cream			Insect Bites Plant Reactions	Yes No	
Benadryl Loratidine			Nasal Congestion	Yes No	
BenGay			Muscle Aches	Yes No	
Chloraseptic Throat Drops Acetaminophen			Sore Throat	Yes No	
Pepto Bismol, Tumms, Maalox			Upset Stomach	Yes No	
Peroxide, Bacitracin			Wounds (Cuts or Abrasions etc.)	Yes No	

I also give my permission for the medications indicated above to be given to my child if needed.

Signature of Parent/Guardian_________________________________**Date**_________________

Health care provider Signature____**Date**__________________

Please sign the bottom of each page

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Name:____________________________________

Prescription Medications:

Health Care Provider, please complete with patient's current regimen for both scheduled and PRN Medications.

Prescription Drug Name	Dose	Route	Schedule & Indications	Comments

Additional Orders:

Primary Health Care Provider: ____

Phone #: _______________________ Fax #: ___________________

License #:____

Address: ____

____

Based on my knowledge of the applicant's health and behavioral characteristics, in my position as his/her primary care health care provider, I deem his/her attendance at a residential camp appropriate:

Health care provider Signature _________________________________Date__________________

Please sign the bottom of each page