Camp Y. T. T.

Please Note: By order of the Health Dept. NO CAMPER may be allowed into camp without this completed form.

MEDICAL AND CONSENT FORM

SIDE 1 - *TO BE COMPLETED BY PARENTS*

CAMPER'S NAME _____ Date of Birth _____
HOME ADDRESS _____ Present Age _____
CITY _____ STATE _____ ZIP _____

Home Phone # _____ Father's Business # _____
Mother's Cell # _____ Cell Phone # _____
Summer Phone # _____ Name of Bungalow Colony _____
In Emergency Call: Name _____ Phone # _____

YOU MUST BRING AN ACTUAL CREDIT CARD WITH YOU. IT WILL BE KEPT IN THE . OFFICE, AND USED ONLY IN CASE YOU NEED SEE A DOCTOR CH"V

Meningococcal Meningitis – FOR PARENTS

Dear Parent:
New York State Public Health Law (NYS PHL) 2167 requires us to distribute information about meningococcal diseased and vaccination to all campers. This law became effective on August 15, 2003.
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 amputations and even death.
Cases of meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.
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 college students.
To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information about the disease at New York State Department of Health Website www.health.state.ny.us or website of the centers for Disease control And Prevention (cdc): www.cdc.gov/ncidod/dbmd/diseaseinfo

Meningococcal Meningitis Response Form

My child has (I have)

- Had the meningococcal meningitis immunization (Menomune) within the past 10 years. Date received _____ (Note: the vaccine's protection lasts for approximately 3 – 5 years. Revaccination may be considered within 3-5 years)
- Read, or have had explained to me the information regarding meningococcal meningitis disease. My child (I) will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider.
- 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 (I) will not obtain immunization against meningococcal meningitis disease.

Signed _____ **Date** _____

STAFF MEMBERS MUST BRING MEDICAL FORMS TO INFIRMARY IMMEDIATELY UPON ARRIVAL.

IMPORTANT NOTE:
The camp office MUST be notified if your child is exposed to any communicable disease during the three weeks prior to camp attendance.

PLEASE SIGN BELOW, DO NOT OVERLOOK!

DEPARTMENT OF HEALTH REGULATIONS REQUIRES THE FOLLOWING AUTHORZATIONS IF YOUR CHILD ATTENDS A SLEEP AWAY CAMP.

PARENT'S AUTHORIZATION

We, the undersigned, custodial parents(s) guardians (s) of _____ a minor, do hereby authorize Camp Y. T. T. and/or it's representative as our agents(s) to act in my/our name, place and stead in any way in which I/we could do if I/we were personally present, with respect to said minor, including without limitation giving consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician or surgeon. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable. This authorization shall remain effective until August 30, 2022, unless sooner revoked in writing delivered to said agent(s).

Parent's Signature _____ **Date**_____

TO BE COMPLETED BY EXAMINING PHYSICIAN

Camper's Name _____

Home Address _____ City _____ State _____ Zip _____

Weight _____ Height _____

Immunization History:
Please record month and year of basic immunization and most recent booster. We do not have it on file from previous years.

Immunization	Date Basic Series completed	Most Recent Booster
DPT or DT		
TETANUS		
POLIO VAC.		
MMR		
PPD/MANTOUX		
HEPATITIS A		
HEPATITIS B		
HIB		
VARICELLA		
PPD	POSITIVE	NEGATIVE
CXRay	Date	Res

Allergies		Comments
PENICILLIN		
SULFA		
CEPHALOSPORINS		
Other Medication		
Food Allergies List foods child is allergic to		
Bees/Insect Bites		

Has child ever had an anaphylactic reactions? Yes. If yes, you must send an EpiPen to avoid charges. (check expiration date)

Medical History

Indicate Date of Illness

Chicken Pox _____
Measles _____
German measles _____
Mumps _____
Hepatitis _____
Pneumonia _____

Indicate if being treated for the following:

Diabetes — seizures
Seasonal Allergy — Rheumatic Fever
Frequent Ear Infection — Frequent Strep Throat

Asthma (if child is being treated for asthma please send along the tubing for the nebulizer as well as all inhalers being used) Make sure nurse is notified before camp begins.

List dates & Desc. of Operations, Serious Injuries, etc._____

_____

_____

Chronic or Recurrent Illness & Suggested Treatment

_____

_____

Individualized Orders

Standard Over-the-Counter Medications (available in the infirmary/First Aid Kit) to be administered at the discretion of an RN unless otherwise indicated by you here.

_____

_____

SPECIAL RESTRICTIONS

Diet _____
Swimming _____
Strenuous Activity _____
Other _____

If the child has a chronic or acute medical condition it is imperative that the camp be notified immediately. All information will be held confidential.

Please detail any special circumstance or conditions that our medical or counseling staff should be aware of that will assist us in the care of your child (e.g. frequent colds, headaches, stomach aches, diarrhea, constipation, vomiting, bed-wetting, sensitivity to insect bites, homesickness, nightmares, anxiety reactions, etc) and what you recommend as treatment.

_____

_____

_____

_____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper listed above is physically able to engage in all camp activities, except as noted above.

Physician's Signature _____ Date _____

Physician's Name _____ Phone _____

Please send completed forms to admin@campytt.com or fax to 212-681-9330