

**Cornell Cooperative Extension of Cortland County  
4-H Camp Owahta, Confidential Health Record**

DIRECTIONS: Please complete ALL Sections. Incomplete information could jeopardize your child's health and safety and/or could prevent them from being able to attend camp due to health code requirements. Parent/Guardians are responsible for the accuracy of the information on this form. Please use blue or black ink as sometimes these forms are photocopied.

**GENERAL INFORMATION**

Circle Week(s) of Attendance:                      Day Camp: 1 2 3 4 5 6                      Resident Camp: 1 2 3 4 5 6

Camper's Name \_\_\_\_\_

Gender  Male  Female    Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Custodial Parent/Guardian's Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone or Pager \_\_\_\_\_

Other Parent/Guardian's Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone or Pager \_\_\_\_\_

**In the Event of an Emergency, if the parent or guardian cannot be reached, please notify:**

Emergency Contact's Name (Relationship to Camper) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone or Pager \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Primary Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Name of Insurance Carrier and Type of Coverage \_\_\_\_\_

Address of Insurance Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Authorization for Release of Information to Medical Providers for an Emergency Relative to the Above Named Camper

\_\_\_\_\_  
Policy Holder's Signature

\_\_\_\_\_  
Date

**MEDICAL & HEALTH HISTORY**

Family Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

Last Physical Examination Date: \_\_\_\_\_ Physician \_\_\_\_\_

Operations or Serious Injuries (Explanation and Dates): \_\_\_\_\_

Dietary Modifications: \_\_\_\_\_

Any specific activities to be encouraged or limited by the camper's physician: \_\_\_\_\_

**MEDICAL AND HEALTH HISTORY CONTINUED**

Check all that apply by giving approximate dates of the last incidence:

- |                            |                               |                       |
|----------------------------|-------------------------------|-----------------------|
| _____ Ear Infection        | _____ Psychiatric Treatment   | _____ Chicken Pox     |
| _____ Hearing Impaired     | _____ Hypertension            | _____ Measles         |
| _____ Heart Defect/Disease | _____ Sleep Walking           | _____ German Measles  |
| _____ Lung Problems        | _____ Bed Wetting             | _____ Mumps           |
| _____ Convulsions/Seizures | _____ Fainting                | _____ Rheumatic Fever |
| _____ Diabetes             | _____ Penicillin Allergy      | _____ Tuberculosis    |
| _____ Bleeding or Disorder | _____ Other Drug Allergies    | _____ Hepatitis       |
| _____ Clotting Disorder    | _____ Environmental Allergies | _____ Mononucleosis   |
| _____ Asthma               | _____ Food Allergies          | _____ Frequent Colds  |

Please provide a brief explanation for any of the dated items above or any additional information that may be relevant to the well being of your child or any other child that may be attending camp. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IMMUNIZATION HISTORY**

In order for your child to attend camp, the parent/guardian must provide all immunization dates under the NYS Health Department Summer Camp Sanitary Code. Please **DO NOT** state that the camper is up to date. Month and year must be written for each shot series. Note that health code does not allow us to retain Health Records on file from summer to summer.

DPT Series:	_____	_____	_____	_____	_____
	1	2	3	4	5 (Booster)
OPV (Polio)	_____	_____	_____	_____	
	1	2	3	4	
Hepatitis B	_____	_____	_____	MMR Series	_____
	1	2	3		1      2
Haemophilus Influenza Type B	_____	_____	_____	_____	Chicken Pox-Varicella _____
	1	2	3		

Tuberculin Test (PPD) Optional-Please Check One: \_\_\_\_\_ Positive      \_\_\_\_\_ Negative      Date \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICATIONS

All Doctor prescribed medications must be accompanied by Camper's name and dispensing instructions from the doctors. All medications must be in the original container. Plastic containers and/or Zip Lock Baggies are unacceptable.

All over the counter medication must be labeled with the camper's name and written instructions provided by the camper's physician stating dispensing instructions, date, and physician's signature. Please be sure to bring your own over the counter medication as NYS Health Department Regulations prevent us from providing over the counter medications. Parent must initial this form for each over the counter medication provided.

All Medication Must Be Left With The Nurse At Registration and May Be Picked Up From The Nurse At The End Of The Week.

**PRESCRIPTION MEDICATION #1**                      **Week 1 2 3 4 5 6**                      **Parent/Guardian Initials** \_\_\_\_\_

**Directions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRESCRIPTION MEDICATION #2**                      **Week 1 2 3 4 5 6**                      **Parent/Guardian Initials** \_\_\_\_\_

**Directions:** \_\_\_\_\_

\_\_\_\_\_

**PRESCRIPTION MEDICATION #3**                      **Week 1 2 3 4 5 6**                      **Parent/Guardian Initials** \_\_\_\_\_

**Directions:** \_\_\_\_\_

\_\_\_\_\_

**PRESCRIPTION MEDICATION #4**                      **Week 1 2 3 4 5 6**                      **Parent/Guardian Initials** \_\_\_\_\_

**Directions:** \_\_\_\_\_

\_\_\_\_\_

**PRESCRIPTION MEDICATION #5**                      **Week 1 2 3 4 5 6**                      **Parent/Guardian Initials** \_\_\_\_\_

**Directions:** \_\_\_\_\_

\_\_\_\_\_

**OVER THE COUNTER MEDICATION #1**                      **Week 1 2 3 4 5 6**                      **Parent/Guardian Initials** \_\_\_\_\_

**Directions:** \_\_\_\_\_

\_\_\_\_\_

**OVER THE COUNTER MEDICATION #2**                      **Week 1 2 3 4 5 6**                      **Parent/Guardian Initials** \_\_\_\_\_

**Directions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MENINGOCOCCAL MENINGITIS VACCINATION CLAUSE**

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 young adults, ages 15 to 25 years of age, have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. A vaccine is available to protect against four types of the bacteria that causes meningitis in the US, Types A, C, Y and W-135. Additional information on meningitis can be obtained from your local health care provider or by visiting the manufacturer's web site [www.meningitisvaccine.com](http://www.meningitisvaccine.com) or the NYS Department of Health web site [www.health.state.ny.us](http://www.health.state.ny.us) and [www.cdc.gov/ncidod/dbmd/diseasinfo](http://www.cdc.gov/ncidod/dbmd/diseasinfo).

On July 22, 2003, The New York State Public Health Law was amended to include section 2167 requiring operations of overnight camps to maintain a completed response form for every camper who attends camp for seven days or more. Please check one of the boxes below.

My child has had the meningococcal meningitis immunization (Menomune TM) within the past 10 years. Date \_\_\_\_\_ .

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 risk of not receiving the vaccine. I have decided that my child will NOT obtain immunization against meningococcal meningitis disease.

**EMERGENCY & MEDICAL RELEASE**

**For The Physicians**

I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations mentioned in this document or in the space provided below. The 4-H Camp Owahta Health Director has my permission to dispense as directed any medication prescribed by me.

**Additional Comments or Recommendations:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Licensed Physician's Name (Print) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Licensed Physician's (Signature) \_\_\_\_\_

**Parent/Guardian Release**

The Health History is correct so far as I know and my child herein described has permission to engage in all camp activities except as noted. If my child's medical history changes prior to his/her attendance, I will notify camp or will not allow him/her to attend camp until he/she is in good health. In addition, I understand that Per Public Health Law, a camp can restrict my child from attending camp if there is a failure to comply with any portion of this health form.

I hereby give permission to the Camp Director or the Medical Personnel selected by the Camp Director to order x-rays, routine test, treatment and necessary transportation for my child. I understand that all actions taken will be in the best interest of my child.

In the event I cannot be reached in an emergency, I hereby give permission to the Physician selected by the Camp Director to secure and administer treatment, including hospitalization for my child, as named above. This completed form may be photocopied for trips out of camp and provided to camp staff if it is related to the health and safety of the child. I understand that my own medical insurance policy will be applied to any medical/hospital cost incurred.

Parent/Guardian Signature

Date