NORTH SHORE HOLIDAY HOUSE

Since 1914

Medical Documents 2024

Health History Form 1 should be completed by the parent or legal guardian.

Health History form 2 should be completed by a Healthcare Provider. All sections of the form should be filled out. An exam date must be written on the form and should be dated within one year of camp attendance. A copy of the campers immunizationrecord should be attached.

If you have any special concerns or questions please contact camp at 631 427 7630 or info@nshh.org.

CAMPER HEALTH HISTORY FORM 1 (This form must be filled out by a Parent/Legal Guardian)

Camper's Name _____ Date of Birth _____/_____/_____
(Last) (First) (Month) (Day) (Year)

Address _____ Phone (____)_____
(Street) (Town) (State) (Zip Code)

Email Address _____ Parent/Legal Guardian Cell Phone (____)_____

Parent/Legal Guardian with legal custody to be contacted in case of illness or injury:

Name _____ Relationship to Camper _____

Email Address_____ Preferred Phone (_____) _____

Second Parent/Legal Guardian or another emergency contact:

Name _____ Relationship to Camper: _____

Email Address _____ Preferred Phone (_____) _____

HEALTH HISTORY: (please check all that apply and explain)

☐ ADD/ADHD	☐ Anxiety	☐ Asthma	☐ Bed wetting
☐ Behavioral issues	☐ Diarrhea/Constipation	☐ Ear infection	☐ Glasses
☐ Headaches	☐ Menstruation	☐ Nosebleeds	☐ Psychiatric diagnosis
☐ Respiratory disorder	☐ Skin problems	☐ Sleep walking	

☐ Other _____

Explanation _____

Past History of Hospitalization/Surgery _____

Special Needs _____

ALLERGIES: ☐ No known allergies

This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.)
☐ Other _____
(Please describe above what the camper is allergic to and the reaction seen)

DIET:
Please describe below any dietary restrictions that need to be followed.

_____

CAMPER HEALTH HISTORY FORM 2 (This form must be filled out completely by a Healthcare Provider)

Please attach a copy of the campers immunization records. Please write an exam date.

Camper's Name _____ Date of Birth _____/_____/_____
(Last) (First) (Month) (Day) (Year)

Name of Healthcare Provider _____ Exam Date _____/_____/_____
(Last) (First) (Must be within the past 12 months)

Please complete the following or attach a copy of most recent physical:

☐ **I have attached a copy of the most recent physical (dated within the past 12 months)**

Height _____ Weight _____ BP _____ Pulse _____ PPD _____
Urinalysis _____ Scoliosis _____ Hearing _____ Vision _____ BMI _____

MEDICATIONS: ("Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. All medications must come in their original packaging and be accompanied by a doctor's written orders.)

☐ This camper **will take** the following daily medication(s) while at camp:

Name of Medication	Date Started	Reason for Taking	When Given	Amount or Dose	How it is given
			▫ Breakfast ▫ Lunch ▫ Dinner ▫ Bedtime ▫ Other _____		
			▫ Breakfast ▫ Lunch ▫ Dinner ▫ Bedtime ▫ Other _____		
			▫ Breakfast ▫ Lunch ▫ Dinner ▫ Bedtime ▫ Other _____		

The following medications are available in the camp infirmary and **will be only given** as needed by camp medical professional with your doctor's approval as per package instructions:

Drug Name (or generic)	Indications	Can be used?	Dosage
Anbesol	Tooth pain	☐ Yes ☐ No	_____
Antibiotic Cream	Superficial Cuts/ Abrasions	☐ Yes ☐ No	_____
Benadryl	Allergic Reaction (Hives, Insect Bites)	☐ Yes ☐ No	_____
Calamine Lotion	Allergic Reaction (Hives, Insect Bites)	☐ Yes ☐ No	_____
Children's Tums	Upset Stomach, Diarrhea	☐ Yes ☐ No	_____
Hydrocortisone Cream 1%	Allergic Reactions (Contact Dermatitis, Bites	☐ Yes ☐ No	_____
Ibuprofen	Pain or Fever	☐ Yes ☐ No	_____
Milk Of Magnesia	Constipation	☐ Yes ☐ No	_____
Swim Ear-Ear Drops	Ear Pain	☐ Yes ☐ No	_____
Tylenol	Pain or Fever	☐ Yes ☐ No	_____

Approval for participation in activities: The above named child is able to participate in an active camp program: ☐ Yes ☐ No

_____ _____
Physician/Healthcare Provider's Signature Date of Examination

_____ _____
Printed Name License Number & Stamp

Address_____

MENINGOCOCCAL DISEASE FACT SHEET

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 by 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 physician. 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?
There are three vaccines available for the prevention of meningitis. The preferred vaccine for people ages 2-55 years is Meningococcal conjugate vaccine (MCV4). This vaccine is licensed as Menactra (sanofi pasteur) and Menveo (Novartis). Meningococcal polysaccharide vaccine (MPSV4; Menomune [sanofi pasteur]), should be used for adults ages 56 and older. The vaccines are 85 to 100 percent effective in preventing the four kinds of meningococcus germ (types A, C, Y, W-135). These four types cause about 70 percent of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

Is the vaccine safe? Are there adverse side effects to the vaccine?
The three vaccines available to prevent meningococcal meningitis are safe and effective. However, the 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 routinely recommended for all adolescents ages 11-12 years, all unvaccinated adolescents 13-18 years, and persons 19-21 years who are enrolling in college. The vaccine is also recommended for people ages 2 years and older who have had their spleen re- moved or have other chronic illnesses, as well as some laboratory workers and travelers to endemic areas of the world.

Who needs a booster dose of meningococcal vaccine?
CDC recommends that children ages 11 or 12 years be routinely vaccinated with Menactra or Menveo and receive a booster dose at age 16 years. Adolescents who receive the first dose at age 13-15 years should receive a one-time booster dose, preferably at ages 16-18 years. Teens who receive their first dose of meningococcal conjugate vaccine at or after age 16 years do not need a booster dose, as long as they have no risk factors. All people who remain at highest risk for meningococcal infection should receive additional booster doses. If the person is 56 years or older, they should receive Menomu.

PARENTAL CONSENT TO TREATMENT

I hereby give permission to NORTH SHORE HOLIDAY HOUSE to provide routine health care, administer medications ordered by a physician, and seek emergency medical treatment including ordering x-rays and/or routine tests. I give permission to the Camp Director to determine if circumstances merit the necessity of a child to be sent home. I give permission for the camp to arrange for necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by NORTH SHORE HOLIDAY HOUSE to secure and administer treatment, including hospitalization for the camper named above. The completed form may be photocopied for trips out of camp. I also understand and agree to abide by any restrictions placed on my child's participation in camp activities. I give permission for my child to receive any and all medication prescribed by the physician noted on the doctor form. I give permission for camp personnel to apply sunscreen to my child.

_____ _____

Parent/Legal Guardian's Signature Printed Name of Parent/Legal Guardian

_____ _____

Name of Minor Date

ACKNOWLEDGEMENT OF INFORMATION REGARDING MENINGOCOCCAL MENINGITIS DISEASE

☐ I have read, or had explained to me, the information regarding meningococcal meningitis disease.

☐ I understand the risks of not receiving the vaccine. My child has not obtained immunization against meningococcal meningitis disease at this time.

☐ My child has received meningococcal meningitis immunization within the last 10 years. (See required immunization record for date).

_____ _____

Parent/Legal Guardian's Signature Printed Name of Parent/Legal Guardian

_____ _____

Name of Minor Date