



# Camp Health and Activity Record

Please print clearly, complete, sign and date this form for each camper.

Mail to: CitiVision, Inc., 126 Carney Road, Ulster Park, NY 12487

Phone numbers: 800-418-2544 or 845-658-8579 Fax: 845-658-8373

## Section I. Camper Information

Last Name		First Name		Middle Initial	Camp Attending
					<input type="checkbox"/> Hoop Heaven
Social Security Number	Date of Birth	Male	Female	Dates attending Camp	<input type="checkbox"/> Girls' Hoop Heaven
		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Wild Wild West

## Parent/Guardian Information

Parent or Guardian	Full Name	Phones & Area Codes
	Home: ( )	
	Address: Apt. #:	Work: ( )
	City State Zip code:	Cell: ( )

## Emergency Information:

IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES)		Phones & Area Codes
Name		
Name		
Please include copy of insurance prescription cards (front & back)  Family Health Insurance Information	Name of Company	Policy Number
	Group Number	Telephone Number
	Parents/Guardian Social Security Number (Required by Medical Facilities if under 18 yrs. old)	
	Parent/Guardian Name:	SS #:

*Camper Information : Campers wishing to leave early must be picked up by parent(s) who sign this health form. Anyone other than the parent, must have written permission signed by the same parent who has signed this form. The camp reserves the right to refuse dismissal without proper identification.*

## Section II: **THIS PORTION MUST BE FILLED OUT and SIGNED BY YOUR PHYSICIAN** (or attach a printout of patient's record from Physician's office) REMEMBER TO HAVE IT SIGNED!

Allergic to:  Penicillin  Sulfa  Aspirin  Other

Any Food Allergies? If yes, explain.

Is child troubled with bed wetting? Yes  No

Able to pursue all normal athletic activities? If no, explain.

**Section II cont'd:**

**CAMPER'S NAME:** \_\_\_\_\_

If camper has had any of the following, please check the box and include year occurred:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Chorea	<input type="checkbox"/> Chronic Intestinal Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Eczema
<input type="checkbox"/> Insulin	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Frequent Colds
<input type="checkbox"/> Non-insulin	<input type="checkbox"/> Frequent sore throats	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Hives
<input type="checkbox"/> Infectious jaundice hepatitis	<input type="checkbox"/> Inflammatory bowel disease	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Measles	<input type="checkbox"/> Malaria	<input type="checkbox"/> Malignancy
<input type="checkbox"/> Operations	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Otitis Media
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio Myelitis	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Rubella German	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Speech Defect	<input type="checkbox"/> Tuberculosis or TB contact
	<input type="checkbox"/> Whooping Cough	

**Proof of immunization, required by law in NYS, must contain specific references to those diseases, dates and doses. Immunizations must be updated if not in accordance with NYS regulations.**

- **Proof of measles** means **two** doses of measles vaccine on or after your first birthday and at least 30 days apart (preferably three months) **and/or a physician-documented history** of the disease or serologic evidence of immunity.
- **Proof of Rubella** means **one** dose of rubella vaccine on or after your first birthday or serologic evidence of immunity.
- **Proof of Mumps** means **one** dose of mumps vaccine on or after your first birthday, **a physician documented history** of the disease, or serologic evidence of immunity.

<b>Immunization History</b>	1st dose	2nd dose	3rd dose	4th dose	last dose
<b>Diphtheria, Tetnus &amp; Toxoid DT 5</b> or more doses required. Most recent dose must be within 10 years prior to entry.					
<b>Polio Vaccine 5 (live oral Sabin)</b> minimum of 18 doses for those 18 yrs of age and under.					
<b>Measles</b>					
<b>Mumps</b>					
<b>Rubella</b>					
<b>Hepatitis B</b>					
<b>Heaemophilus influenza B</b>					
<b>Varicella (chicken pox)</b>					

The health and immunization history is correct so far as I know. My son/daughter has permission to engage in all prescribed camp activities which include, but are not limited to horseback riding, water sports, ropes course. I realize that my camper's picture and/or testimony may be used in the future promotion of CitiVision, Inc.

CitiVision, Inc. is a non-profit, charitable organization dependent on God and His people. Those who use CitiVision's facilities and/or engage in related activities, waive and release CitiVision, Inc. from any claim for personal injury or property damage. Attendees agree to carry insurance and/or cover the expenses related to personal injury or property damage.

**I understand that all medicines, vitamins, etc. must be given to the camp nurse upon arrival and that they must be in the original containers. No medication may be given without the MEDICATION FORM completed and signed by my child's health care provider.** Illegal drugs, weapons and similar items are not permitted at camp. CitiVision reserves the right to search for and remove such items from anyone suspected of possessing them.

I hereby give permission to the medical personnel selected by the camp director, to order x-rays, routine tests and treatment for my son/daughter. In the event I cannot be reached, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for and to order injection, anesthesia, and /or surgery for my child as named above. This form may be photocopied for use out of camp.

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print signature here:** \_\_\_\_\_

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Section III: CitiVision Camp Medication Form (must be signed by physician)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Camp nurse may administer to my son/daughter, the following from our camp health center, if needed while attending camp.

Physicians signature is required.

Medication	Dosage	physician approval order
<b>Acetaminophen</b> (compared to active ingredient in Tylenol)	per label instructions by age/weight	___yes or ___ no
<b>Ibuprofen</b> (compared to active ingredient in Advil)	per label instructions by age/weight	___yes or ___ no
<b>DiphenhydramineHCl</b> (compared to active ingredient in Benadryl)	per label instructions by age/weight	___yes or ___ no
<b>Guaifenesin usp</b> (compared to active ingredient in Robitussin)	per label instructions by age/weight	___yes or ___ no

Camp nurse may administer to my son/daughter the following prescription medications, vitamins, herbs, and or dietary supplements, as ordered by my child's physician.

**Physician's signature is required:** \_\_\_\_\_

Medication Name	Route	Dose	Frequency & Indications	Comments

Additional Physician orders:

**Signature of approving licensed health care provider authorized to prescribe medications:**

Provider: \_\_\_\_\_

Print Name: \_\_\_\_\_

Phone Number: (    ) \_\_\_\_\_

Date: \_\_\_\_\_

*If you have any concerns or questions about this form, call the CitiVision office - 800-418-2544*

**Internal use only below this line!**

Screened by: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Yes

No

Updates or additions to the medical records?  
 Have needed medications been received?  
 Have all medical attention requirements been described?


Dear Parent/Guardian,

Your child has registered to attend CitiVision camp. According to New York State Public Health law, overnight children's camps are now required to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers **who attend camp for 7 or more nights.**

~ **Meningococcal Disease Fact Sheet**  
~ **Meningococcal Meningitis Vaccination Response Form**

CitiVision is required by law to maintain a signed Meningococcal Meningitis Vaccination Response Form for each camper that remains at the camp for 7 or more nights.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at [www.meningitisvaccine.com](http://www.meningitisvaccine.com).

If you have questions regarding meningococcal disease that are not answered by the enclosed fact sheet, please talk to your local health care provider.

We hope this information will be helpful to you.

Sincerely,

*Hal Rich*

Hal Rich  
COO CitiVision, Inc.

**MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM**

Camper Info:  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

New York State Public Health Law requires CitiVision, Inc. to maintain a complete Response Form for every camper who attends camp for seven (7) or more nights.

**Check one box and sign below:**

- My child has had the meningococcal meningitis immunization (Menomune TM) or (Menactra) **Please circle one.** within the past 10 years. Date received: \_\_\_\_\_  
(Note: The vaccine's protection lasts for approximately 3-5 years. Re-vaccination may be considered with 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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian Signature)

Camp Attending: Wild Wild West \_\_\_\_\_ Hoop Heaven \_\_\_\_\_ Dates Attending: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**New York State Department of Health/ Bureau of Communicable Disease Control**

**Meningococcal Disease:** Information for Parents of Children at 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 a 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 freshman living in the 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 five 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 the 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,

<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, <http://www.acha.org>