Medical Packet for All Camp Participants
2022 DIOCESAN SUMMER CAMPS
Department of Youth and Young Adult Ministries
Diocese of the Armenian Church of America (Eastern)

A. Participant Information and Health Insurance Form

The following information must be thoroughly filled in by the parent/guardian of a minor or by an adult staff member.

Health exams must be completed by an approved licensed medical professional at least every two years; however, **an updated and signed form is required annually**. This information provides camp health care personnel the background to provide appropriate care based on the individual's needs. Keep a copy of the completed packet for your records. Any changes to this packet should be provided to camp health care personnel upon the participant's arrival in camp. **These forms will need to be uploaded to your online ACTIVE family portal by JUNE 1 for St. Vartan Camp and by JULY 1 for Hye Camp.** Please make sure your scans are bright and legible.

PLEASE NOTE: Forms C and D must be completed by a medical professional, with a signature or stamp at the bottom of Form D verifying completion. Without these completed and signed forms, a participant will not be permitted to attend camp.

Should you have any questions or need further assistance, please contact:
St. Vartan Camp: Kathryn Ashbahian at (215) 452-8322 or KathrynA@armeniandiocese.org
Hye Camp: Jennifer Morris at (248) 648-0702 or JenniferM@armeniandiocese.org

Name of Participant: _____

Circle Session(s) Attending: **A/A1** **B/B1** **C/C1** **Hye Camp**

Insurance Information: Is the participant covered by family medical/hospital insurance? ___ Yes ___ No

If so, indicate carrier or plan name: _____ Group #: _____

Name and Date of Birth of individual who carries the plan: _____ DOB: _____

You MUST cut and tape a photocopy of the FRONT of your health insurance card here.	You MUST cut and tape a photocopy of the BACK of your health insurance card here.

B. Participant Health History Form

The following information can be filled in by the parent/guardian of a minor or by an adult staff member.

Participant's Name: _____

ALLERGIES: List all known allergies (medical, food, or other), as well as the reaction and management of the allergy.

_____

_____

_____

_____

Has/Does the participant:	Yes	No	Has/Does the participant:	Yes	No
1. Have any recent injury, illness or infectious disease?			16. Ever had back problems?		
2. Have chronic or recurring illness/condition?			17. Ever had problems with joints (e.g. knees, ankles)?		
3. Ever been hospitalized?			18. Have an orthodontic appliance?		
4. Ever had surgery?			19. Have any skin problems (e.g. itching, rash, acne)?		
5. Have frequent headaches?			20. Have diabetes?		
6. Ever had a head injury?			21. Have asthma?		
7. Ever been knocked unconscious?			22. Have mononucleosis in the past 12 months?		
8. Wear glasses, contacts, or protective eyewear?			23. Have problems with diarrhea/constipation?		
9. Ever had frequent ear infections?			24. Have problems with sleep walking?		
10. Ever passed out during or after exercise?			25. If female: Have abnormal menstrual history?		
11. Ever been dizzy during or after exercise?			Age of first menses:_____		
12. Ever have seizures?			26. Have a history of bed-wetting?		
13. Ever had chest pain during or after exercise?			27. Ever had an eating disorder?		
14. Ever had high blood pressure?			28. Ever sought professional help for emotional difficulties?		
15. Ever been diagnosed with a heart murmur?					

Please explain any "yes" answers from the above general questions, noting the number of each question:

_____

_____

_____

_____

_____

Please provide <u>honest</u> information about the participant's <u>behavior</u> and <u>physical</u>, <u>emotional</u>, or <u>mental health</u> of which the camp should be aware in order to meet his/her individual needs:

_____

_____

_____

_____

_____

C. Examination and Immunization Form

The following information must be completed by a Licensed Medical Professional.

Name: _____ was examined on _____/_____/_____
Height: _____ Weight: _____ BP: _____

Name of Family Dentist/Orthodontist: _____ Phone: _____
Dentist/Orthodontist Address: _____

1. In my opinion, the above individual ____IS ____ IS NOT able to participate in an active camp program.

2. Describe all conditions for which the participant may be under the care of a physician. Note any limitations and/or restrictions while at camp. All medications and treatments prescribed should be listed on Form D:

_____
_____
_____

3. Please list any medically-prescribed meal plan or dietary restrictions:

_____
_____
_____

4. Please check off any of the following that the participant has had:

_____ Measles
_____ Chicken Pox
_____ German Measles
_____ Mumps

_____ Hepatitis A
_____ Hepatitis B
_____ Hepatitis C
_____ COVID-19

_____ TB Mantoux Test
Date of last test: _____
Result: _____ Positive
_____ Negative

5. Please complete the box below, OR attach a printed immunization record from your doctor's office:

All dates of immunization for:	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**
COVID-19 (Pfizer / Moderna / J&J)									
Diptheria Tetanus (DTaP)									
Hepatitis A (HepA)									
Hepatitis B (HepB)									
Haemophilus Influenzae B (HIB)									
Influenza									
Measles Mumps Rubella (MMR)									
Pneumococcal (PCV13/PPSV23)									
Polio (IPV)									
RotaVirus									
Varicella - *Chicken Pox* (Var)									

D. Standing Orders for the Administration of Medications Form

The following information must be completed by a Licensed Medical Professional.

In order to administer medications at St. Vartan Camp / Hye Camp, our Diocesan Summer Camps require an authorized prescriber's (MD, PA, APRN) written order **and** a parent or guardian's authorization for the nurse or camp personnel to administer medications. Medications must be in **the original pharmacy prepared containers** and **labeled with the name of the child**, name of the drug, strength, dosage, frequency, authorized prescriber's name and date of the original prescription. Any modifications to the prescription bottle instruction must have a signed doctor's note. All medications will be returned on the final day of camp; medication that is not picked up on the last day of camp will be destroyed.

PARTICIPANT NAME: _____

Prescription Medications and Treatments

Please complete with current regimen for both scheduled and as-needed medications, in addition to any other orders deemed necessary to be implemented by the camp nurse (i.e., dressing changes, cast care, special dietary instructions).

Medication	Dose, Route, and Frequency	Indication, other comment(s)

Standard Over-the-Counter Medications, First Aid, and Preventative Treatment

The brand or generic equivalent medication listed below is available at camp, so please DO NOT bring the below medications to camp. Over-the-counter medication and treatment will be administered at the nurse's discretion, ONLY if approval is indicated by the participant's licensed medical professional with a distinct √ ***Check Mark*** *to the left of the item.*

	Acetaminophen (e.g. Tylenol)		Ibuprofen, (e.g. Advil, Motrin)		Naproxen (e.g. Aleve)
	PMS/Menstrual Relief (e.g. Midol, Pamprin)		Body Powder (e.g. Gold Bond)		Dietary Fiber (e.g. Metamucil, Benefiber)
	Cough Medication (e.g. Robitussin, Nyquil)		Decongestant (e.g. Dimetapp, Sudafed)		Antihistamine (e.g. Benadryl, Claritin)
	Throat Spray (e.g. Chloraseptic)		Cough Drops (e.g. Halls)		Canker Sore Relief (e.g. Orajel)
	Antacid (e.g. Tums, Mylanta, Maalox)		Anti-diarrheal (e.g. Imodium, Pepto Bismol)		Laxative (e.g. Milk of Magnesia, Dulcolax)
	Antiseptic Cleanser (e.g. Bactine)		Antibiotic Ointment (e.g. Neosporin)		Steroidal Ointment (e.g. Hydrocortisone)
	Topical Antihistamine (e.g. Benadryl, Caladryl)		Sun care (e.g. Sunscreen, Aloe Vera, Solarcaine)		Bug Repellent (e.g. Off!)
	Eye Drops/Lubricant (e.g. Visine)		Swimmer's Ear Drops (e.g. Auro-Dri, Swim Ear)		Athletes Foot Care (e.g. Tinactin)

I have completed and verified the medical information on Form C and Form D.

Signature of Licensed Medical Professional: _____

Printed: _____ **Date:** _____

Address: _____

Phone: _____ **Fax:** _____

I HAVE READ THE ABOVE STATEMENTS AND AGREE TO THEIR TERMS.

Parent/Guardian/Staff Signature: _____ **Date:** _____

E. Meningococcal Meningitis Vaccination Response Form

The following letter must be reviewed, completed, and signed by a Parent/Guardian/Staff member.

Dear Parent/Guardian/Staff Member:

We are writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. We are required, as overnight children's camps, to distribute information about meningococcal disease and vaccination to the parents and guardians of all campers who attend camp for seven or more nights.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal disease can cause serious illness such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, and limb amputation, in as many as one in five of those infected. Ten to 15 percent of those who get meningococcal disease will die. Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing, or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that cause meningococcal disease even before they know they are sick. Anyone can get meningococcal disease, but certain people are at increased risk, including teens and young adults 16 – 23 years old and those with certain medical conditions that affect the immune system.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause meningococcal disease in the United States. The Center for Disease Control and Prevention (CDC) recommends a single dose of MenACWY vaccine at age 11 through 12 years with a booster dose given at age 16 years. Children are not routinely recommended to receive the MenACWY vaccine prior to the recommended ages, unless they have certain underlying medical conditions which increase their risk of disease. The meningococcal B (MenB) vaccine protects against a fifth strain of meningococcal bacteria which causes meningococcal disease. Young adults aged 16 through 23 years may be vaccinated with the MenB vaccine and should discuss the MenB vaccine with a healthcare provider.

We encourage you to carefully review the Meningococcal Disease Fact Sheet available on the New York State Department of Health website at: http://www.health.ny.gov/publications/2168.pdf.

Information about the availability and cost of meningococcal vaccine can be obtained from your healthcare provider or your local health department. Please note that St. Vartan Camp / Hye Camp does not offer meningococcal immunization services.

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E. Meningococcal Meningitis Vaccination Response Form (Cont'd)

St. Vartan Camp / Hye Camp is required to maintain a record of the following for all camp participants:

1. Receipt and review of meningococcal disease and vaccine information; AND EITHER
2. Certification that the camper has been immunized against meningococcal meningitis within the past 10 years; OR
3. An understanding of meningococcal disease risks and benefits of vaccination at the recommended ages and the decision not to obtain immunization against meningococcal meningitis at this time.

To learn more about meningococcal meningitis and the vaccine, please feel free to contact us and/or consult your child's physician. You can also find information about the disease at the website of the Centers for Disease Control and Prevention: www.cdc.gov/vaccines/vpd-vac/mening/default.htm.

Please complete and sign this Meningococcal Meningitis Vaccination Response Form.

Thank you for your attention to this matter. Please feel free to contact our office with any further questions.

The Department of Youth and Young Adult Ministries
Kathryn Ashbahian and Jennifer Morris

PLEASE CHECK ONE STATEMENT AND SIGN BELOW:

_____ My child has had the meningococcal meningitis immunization within the past 10 years.

Date received: _____

_____ I have read, or have had explained to me, the information enclosed regarding meningococcal meningitis disease. I understand the risks of not having the vaccine. I have decided that my child will NOT obtain immunization against meningococcal meningitis disease.

Participant Name: _____ **DOB:** _____

Parent/Guardian/Staff SIGNATURE: _____ **Date:** _____

F. Emergency Contact and Pick-Up Authorization Form

Please complete one form per family.

Camper/CIT Name(s): _____

1. In the event that I am NOT available to pick my child up from the camp session, especially if they contract COVID-19 or other communicable diseases, I (the parent/guardian) authorize the following <u>TWO</u> individuals to be the Emergency Contacts to pick up my child.

I have verified that both contacts will be willing and available to pick up my child during the duration of the camp session. Each of the contacts added below must be within driving distance from camp and available for same-day pickup.

Name: _____

Address: _____

Relationship: _____

Home Phone: _____ **Cell Phone:** _____

Name: _____

Address: _____

Relationship: _____

Home Phone: _____ **Cell Phone:** _____

2. Please list any person(s) NOT authorized to pick up your child/children:

If there are any custody issues of which St. Vartan Camp / Hye Camp should be aware, please attach court documentation, if applicable.

_____

3. Please fill in the following information if your child/children is/are traveling home by a chartered bus/van:

I authorize _____ to chaperone my child/children to the designated drop off point in my community.

PLEASE NOTE: Any person unfamiliar to our summer camp staff will be required to show proof of identification. Under NO circumstances will the child be released to anyone other than those listed above without WRITTEN permission from the parent or legal guardian to the Camp Director(s) or Department of Youth and Young Adult Ministries staff.

Parent/Guardian SIGNATURE: _____ **Date:** _____