

## Dear Campers, Parents, Guardians, Leaders, and Friends:

When we think of day or resident camping, we should think of fun and excitement. Yet even more importantly, at Schiff Scout Reservation, health and safety are always our *top priority*. Sometimes, illness and injury can sometimes accompany the camp experience. In order to facilitate a more positive stay at Theodore Roosevelt Council Camps, we need to have updated and accurate health information for your camper.

- Please download the **Annual Medical Form** from [www.trcbsa.org](http://www.trcbsa.org). Please sign all forms, have your child's physician complete, sign and stamp them where necessary, and give them to your unit before your camper's arrival. Please note writing in "up to date" for immunization records is NOT ACCEPTABLE. Immunization records can be filled in on the **Annual Medical Form** and the **Supplemental Immunization and Meningitis Vaccination Response Form**
- *Timely and full completion of these items will greatly expedite your check-in upon arrival at Camp.*
- *Unfortunately, we cannot admit campers with incomplete medical forms; no overnight accommodation is possible with incomplete forms. We DO NOT keep forms "on file" for use in subsequent years.*

It is very important to be thorough when completing these forms. Knowledge of allergies, recent injuries, immunization records, and any other special circumstance will assist the Camp staff in providing an optimal experience for your camper. (It is also a NYS Health Department requirement).

### 1. **Prescription Medications and Over-the-Counter (OTC) Medications brought to Camp**

Any prescription medications brought to Camp must be brought to the Camp Health Officer immediately upon registration. No medications, prescription or over-the-counter (OTC) or supplements, may be kept by participants. Campers who conceal the possession or use of medication will be discharged from camp.

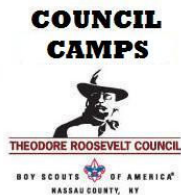
By NY State Law, over-the-counter and prescription medications may not be administered to campers without individual written orders by a licensed physician. Please do not send non-prescription (over-the-counter) medications or supplements with your camper.

The Medication Authorization Form must be completed by each participant's primary health care provider to allow the administration of any medication. Prescription medications and supplements must remain in their original container(s), must clearly state the camper's name, contents, and the physician's instructions; and must include the dates of use, name of prescription, dosage amount, and time(s) of day to be administered. The use of medication is closely monitored to protect all campers, and must be stored under lock in the Camp Health Office. Please reclaim it from the Camp Health Officer at the close of the camper's session.

2. **Consent to Treat form** must be filled out completely and signed by the parent or guardian.
3. **Insurance Coverage:** Please make sure you have completed the **insurance information** on the **Annual Medical Form** and the **Consent to Treat form** . *All campers must carry their own medical insurance.*
4. **General Health:** The following should be discussed with your camper prior to arrival at camp. Please advise your camper to wash her or his hands regularly with soap and water, to brush teeth daily, shower as appropriate, and care to other hygienic needs. Proper rest, protection from sun exposure, good nutrition, and moderation in exercise should also be discussed. Children should also not touch each other or share personal items or food.

**Code of Conduct:** All participants are expected to follow rules outlined in the **Camp Unit Leaders Guide**. This includes the ability to self-monitor and the ability for participants to foresee the consequences of their actions. Theodore Roosevelt Council BSA does not provide one:one supervision. The Camp will provide reasonable accommodations, but will remove from the program campers who present an undue risk to themselves or others; and those who significantly detract from the Camp experience.

Thank you for choosing **Schiff Scout Reservation** for your camping experience. The safety, health and happiness of your camper are our priority.



## Supplemental Immunization and Meningitis Vaccination Response Form

CAMPER NAME \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_

Parent Name \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_

### HAEMOPHILUS INFLUENZAE TYPE B (HIB) VACCINATION

NY CLS Pub Health § 2164 (2007)

Administered (mm/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_ Lic. Physician Signature \_\_\_\_\_ Lic. No. \_\_\_\_\_

### MENINGOCOCCAL VACCINATION RESPONSE

*Check ONE of the boxes and sign below. For campers under the age of 18, signature of parent or guardian is also required.*

My child has:

- had the meningococcal meningitis immunization within the past 10 years. **Date of shot** \_\_\_\_/\_\_\_\_/\_\_\_\_  
[Note: If your child received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.]
- read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccination. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### Meningococcal Vaccination Requirements

On July 22, 2003, Governor Pataki signed **New York State Public Health Law (NYS PHL) §2167** requiring overnight children's camps to distribute information about meningococcal disease and vaccination to all campers who attend camp for 7 or more consecutive days. This law became effective on August 15, 2003. Onteora Scout reservation is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal disease and vaccine information signed by the camper's parent or guardian; AND
- Information on the availability and cost of the new meningococcal meningitis vaccine (Menactra™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

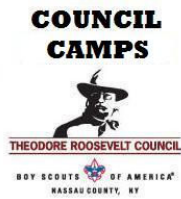
Meningococcal meningitis is rare. However, when it strikes, its flu like symptoms make diagnosis difficult. If not treated early meningococcal meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningococcal disease among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 2,500 Americans each year and claims about 300 lives.

In February 2005, the CDC recommended a new vaccine, known as Menactra™, for use to prevent meningococcal disease. The previous version of this vaccine, Menomune™, was first available in the United States in 1985. Both vaccines are 85% to 100% effective in preventing the 4 kinds of the meningococcal germ (types A, C, Y, W-135). These 4 types cause about 70% of the disease in the United States. 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).

for about one-third of cases in adolescents, it does not prevent all cases of meningococcal disease. 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).

Please complete the **Meningococcal Vaccination Response** and return it to as part of your camper's health history. To learn more about meningitis and the vaccine, please feel free to contact your local health department and/or consult your child's physician. You can also find information about the disease at the New York State Department of Health website: [www.health.state.ny.us](http://www.health.state.ny.us), and the website of the Center for Disease Control and Prevention (CDC): [www.cdc.gov/ncidod/dbmd/diseaseinfo](http://www.cdc.gov/ncidod/dbmd/diseaseinfo).



**Individualized Medication Orders**  
**STANDARD OVER THE COUNTER/ PRN MEDICATIONS**

**CAMPER NAME** \_\_\_\_\_ **Date of Birth (mm/dd/yyyy)** \_\_\_\_\_

**CAMPER WEIGHT:** \_\_\_\_\_ lbs.

**Healthcare Provider Name:** \_\_\_\_\_ **Office Phone:** (    ) \_\_\_\_\_ - \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

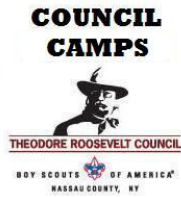
**Address:** \_\_\_\_\_ **License #** \_\_\_\_\_

Stamp:

The following medications are available in the Health Lodge and will be administered at the discretion of a RN, if **approval** is indicated by the Healthcare Provider.) Do not send these medications to camp; they are at the Health Lodge.

<b>Drug Name</b>	<b>Route (Please circle preferred formulation(s))</b>	<b>Dosage</b>	<b>Schedule</b>	<b>Camp Healthcare Provider Order</b>	<b>Comments</b>
BENADRYL	PO (elixir, chewable tabs, pills)	Per label instructions by age/wgt	Q 6 hr prn for allergic reaction (hives, insect bite)	YES NO	
CEPACOL	PO (lozenges)	Per label instructions by age/wgt	Q 2 hr (no > 6 doses in 24 hr and no fever)	YES NO	
DIMETAPP	PO (elixir, tabs)	Per label instructions by age/wgt	Q 6 -8 hr prn for nasal congestion/drainage	YES NO	
DRAMAMINE	PO (chewable tabs-50mg)	Per label instructions by age/wgt	Q 6 -8 hr prn for motion sickness	YES NO	
IBUPROFEN (Motrin)	PO (chewable tabs, suspension, tabs)	Per label instructions by age/wgt	Q 6 hr prn for pain or fever > _____ °F	YES NO	
MYLANTA	PO (chewable tabs)	Per label instructions by age/wgt	BID-TID prn for stomach upset	YES NO	
PEPTO-BISMOL	PO (liquid, chewable tabs)	Per label instructions by age/wgt	Q 30 min to 1 hr prn for diarrhea (no > 8 doses in 24 hr)	YES NO	
ROBITUSSIN	PO (syrup)	Per label instructions by age/wgt	Q 4 hr prn for cough	YES NO	
TYLENOL	PO (chewable tabs, elixir, tabs)	Per label instructions by age/wgt	Q 4 hr prn for pain or fever > _____ °F	YES NO	





**Consent To Treat And Waiver**  
**Must Be Signed To Enable Attendance:**

**CONSENT TO TREAT**  
**PECONIC BAY MEDICAL CENTER**

**CAMPER NAME** \_\_\_\_\_ **Date of Birth (mm/dd/yyyy)** \_\_\_\_\_

**Custodial Parent Name (print)** \_\_\_\_\_ **Daytime Phone Number ( )** \_\_\_\_\_ - \_\_\_\_\_

I/We, the undersigned, custodial parent(s)/guardian(s) of: \_\_\_\_\_  
(Print Name of Minor), A minor, do hereby authorize Schiff Scout Reservation, Theodore Roosevelt Council, or any authorized representative thereof, as our agent(s) to act in my/our name, place, and stead in anyway 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 on the staff of or engaged by Peconic Bay Medical Center, whether such diagnosis or treatment is rendered at the office of said physician or at Peconic Bay Medical Center.

With respect to consent to diagnostic procedures or medical care, it is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on part of my/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/her best judgment may deem advisable.

This authorization shall remain effective until \_\_\_\_\_, 2\_\_\_\_\_, unless sooner revoked in writing and delivered to said agent(s).

**NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD**

I have read the above information, and give my permission for the authorized staff of Schiff Scout Reservation and Theodore Roosevelt Council to administer treatments according to the Camp's protocols, to my child. In full recognition and appreciation of the dangers and hazards inherent in the camp experience, which I have conveyed to my child, I agree to assume all risks and responsibilities arising out of this activity and any others undertaken as an adjunct thereto; and further, I do for my child, myself, my heirs, and personal representatives hereby release, hold harmless, and forever discharge Theodore Roosevelt Council, Boy Scouts of America, its officers, agents, and employees against any and all claims, demands, and actions or causes of action, on account of damage to personal property, or personal injury or death which may result from my child's participation in the camp experience. In addition, I have instructed my child to follow all Camp rules and to seek immediate guidance from Camp counselors and administrators if a serious problem should arise.

In witness whereof, I have caused this authorization and release to be executed this \_\_\_\_\_ day of \_\_\_\_\_, 2010.

\_\_\_\_\_  
(Signature of custodial parent or guardian) \_\_\_\_\_ (Date)

\_\_\_\_\_  
(Witness) \_\_\_\_\_ (Date)

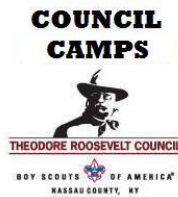
**Custodial Parent(s)/Guardian(s) Contact Information**

Permanent Address: \_\_\_\_\_

Phone Numbers: Home: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Mobile:( ) \_\_\_\_\_ - \_\_\_\_\_

Insurance Carrier/Plan: \_\_\_\_\_ Policy/I.D.# \_\_\_\_\_

Insurance Company: Address/Phone #: \_\_\_\_\_



## Did you remember to:

1. Keep a copy of this entire Health Form for your records.
2. Provide **parent signatures** on each of the following pages:
  - **Annual Medical Form**, Part A – Medications
  - **Annual Medical Form**, Part C - Waivers and Permission
  - **Supplemental Immunization and Meningitis Vaccination Response Form**
  - **Consent To Treat** for Peconic Bay Medical Center And Waiver
3. Have **physician/health care provider** complete each of the following pages and provide signatures:
  - **Annual Medical Form**, Part A – Medications
  - **Annual Medical Form**, Part B – Physical Examination
  - **Supplemental Immunization and Meningitis Vaccination Response Form**
  - **Individualized Medication Orders** for Over-the-Counter Medications
  - **Individualized Medication Orders** for Prescription Medications
4. Provide a copy of your **Health Insurance Card** (both front and back)

If you have any questions, please email at [inquiry@trcbsa.org](mailto:inquiry@trcbsa.org) or call 516 797-7600 before July 1. From July 1- August 15, please call the camp at 631.929.2827.

Please recheck these forms for accuracy and completion prior to submission to the camp for attendance at Day Camp, the Counselor-In-Training Program, Wauwepex Webelos Camp, or other resident camp programs offered by Theodore Roosevelt Council B.S. A.

Thank you again for choosing **Schiff Scout Reservation** for your camping experience. The safety, health and happiness of your camper is our priority.