Stomping Ground Medical Packet

This packet contains the medical forms that we'll ask you to upload on CampBrain in order for your camper to attend camp!

There are 4 forms in total.

☐ 1. **Healthcare Provider Form**

This form must be ***completed by a physician*** to assure that your camper is in appropriate physical health to attend camp. You may use our form, a form from school, or a form from a doctor.

☐ 2. **OTC/Prescription Medication Form**

This form must be ***completed by a physician*** and ***signed by a caregiver*** in order for your camper to receive **any** medication (this includes over-the-counter medications such as ibuprofen).

☐ 3. **Immunization Form**

This is your camper's immunization history. You may use our form, a form from school, or a form from a doctor.

☐ 4. **Meningococcal Meningitis Vaccination Response Form**

This form is required by the New York State Department of Health, and is just a record of the MCV4 immunization.

*You do **not** need to scan or upload this page into CampBrain.

Healthcare Provider Form

(You may also use a copy from your doctor or school)

Camper Name _____ **Date of Birth** _____

To be completed by Parent/Guardian:

☐ I understand that the physical must be within 24 months of the camper's entire stay at camp.

Please select one of the 3 options:

1. Submit a copy of any medical form used previously for school or sports, as long as it includes
    a. Date of examination
    b. Statement of good health
    c. Full immunization history
2. The physician may choose to use their own form as long as it contains the information above.
3. The physician may choose to complete the 3 sections below
    a. If so, an additional immunization form must be completed

To be completed by Physician:

I examined _____ on _____.
(camper name) *(date)*

It is my opinion that they are physically able to engage in camp activities, *except* as follows:

_____

_____

_____

With these precautions:

_____

_____

_____

Healthcare Provider Name _____ **License #** _____

Address _____ **Phone** _____

Signature _____ **Date** _____

Over-The-Counter & Prescription Medication Form

(page 1)

Standing Individualized Orders for:

Camper Name _____ **Date of Birth** _____

This includes but is not limited to: prescription medications, over-the-counter medications, inhalers, ointments, prescription face wash, homeopathic remedies, and vitamins. Campers may not keep medication in the cabin with them; it is distributed at wake-up, meal times, bedtime, and between activities.

Drug Name	Route	Dosage	Schedule + Indications	Comments

Standard OTC/PRN Medications:

The following medications are available in the health center and will be administered at the discretion of the Camp Nurse if approval is indicated by circling 'YES' below. **No response on this section will assume the answer is no.**

Drug Name	Provider Order	Drug Name	Provider Order
Tylenol/Acetaminophen *(discomfort/fever)*	**YES NO**	**Visine** *(drops - eye irritation)*	**YES NO**
Advil/Ibuprofen *(discomfort/fever)*	**YES NO**	**Calamine Lotion** *(topical - skin irritation)*	**YES NO**
Benadryl *(allergies)*	**YES NO**	**Tums** *(heartburn/upset stomach)*	**YES NO**
Colace *(stool softener)*	**YES NO**	**Miralax** *(laxative)*	**YES NO**
Pepto Bismol *(upset stomach)*	**YES NO**	**Dayquil/Nyquil** *(decongestant)*	**YES NO**

Over-The-Counter & Prescription Medication Form

(page 2)

Healthcare Provider Name _____ **License #** _____

Address _____ **Phone** _____

Signature _____ **Date** _____

☐ **I have read the doctor's documentation in this form and I agree with the physician's individual medical orders for my camper.**

Caregiver/Parent Name _____

Signature _____ **Date** _____

OR

No medications administered.

☐ *By checking this box* and signing below, I acknowledge that my camper will NOT be receiving prescription medication and Stomping Ground staff will NOT provide ANY over-the-counter medications as listed above.*

*Only check this box and sign if you wish for your camper to not be able to receive any medication, including over-the-counter medications as listed above.

Caregiver/Parent Name _____

Signature _____ **Date** _____

Immunization Form

(You may also use a copy from your doctor or school)

Camper Name _____ **Date of Birth** _____

This immunization list is in line with the NYS School vaccination schedule.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Latest
DTaP or TDaP *Diphtheria, tetanus, pertussis*	_____ (MM/YYYY)	_____	_____	_____	_____	_____
MMR *Mumps, measles, rubella*	_____	_____				
IPV *Polio*	_____	_____	_____	_____		
HIB *Haemophilus influenzae type B*	_____	_____	_____	_____		
PCV *Pneumococcal*	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Hepatitis A	_____	_____				
Chicken Pox *Varicella*	_____	_____				

Tetanus, Pertussis Booster _____

The immunizations listed below are optional to attend Stomping Ground, but we still collect documentation.

MCV4 *Meningococcal meningitis*	_____		
H1N1 *Swine flu*	_____	_____	
Flu Shot	_____ *(latest)*		
Covid 19	_____	_____	_____ *(booster)*

Meningococcal Meningitis Vaccination Response Form

Camper Name _____ **Date of Birth** _____

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

The Centers for Disease Control and Prevention recommends two doses of MenACWY vaccine (Brand names: Menactra, Menveo) for all healthy adolescents 11 through 18 years of age: the first dose is given at 11 or 12 years of age, with a booster dose at 16 years of age. Children and adolescents with certain medical conditions may need to begin the MenACWY series at a younger age and/or receive additional doses. Consult with your child's healthcare provider regarding any medical conditions they may have.

If the first dose is given between 13 and 15 years of age, the booster should be given between 16 and 18 years of age. If the first dose is given after the 16th birthday, a booster is not needed.

Young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series (Brand names: Trumenba, Bexsero). Parents/guardians should discuss the Meningococcal B vaccine with a healthcare provider.

Please read the meningococcal meningitis information here before completing your response below.

Check the box that applies to your camper and sign below.

☐ I have received and reviewed the information above regarding meningococcal meningitis. My child has received meningococcal immunization (Menactra or Menveo) within the past 10 years.

Date received:

OR

I have received and reviewed the information above regarding meningococcal meningitis. I understand the risks of meningococcal meningitis and the benefits of immunization at the recommended ages.

☐ I have decided that **my child**, who is ***younger than 11 years of age***, will **not** obtain immunization against meningococcal disease at this time; or

☐ I have decided that **my child**, who is ***11 years of age or older***, will **not** obtain immunization against meningococcal disease at this time.

Signed _____ **Date** _____

(Caregiver/Parent)