

WORD OF LIFE CAMPS- The following are steps to guide you through our camp medical forms

STEP # 1 – Complete Required Forms

- Health & Activity Record:** Parent or Guardian must complete, sign & date this form.
- Medication Form:**
 - Required if your camper is to take medication in any form while at camp, including prescription medication, over-the-counter-medicine, vitamins, herbs, or dietary supplements.
 - Must be completed and signed by a licensed health care provider (authorized to prescribe medications).
 - Without this form, your camper will not receive any medication while at camp.
- Meningococcal Meningitis Vaccination Response:** *If your camper is staying seven or more nights at camp, New York State Public Health Law requires Word of Life to inform and warn of the risks of Meningitis as well as maintain documentation for each camper (see Meningitis Fact Sheet, if applicable).*

STEP # 2 – Return the Forms -- Make a copy of all completed forms for your records.

1) **If camper is registered with a Group, please return completed forms to Group Leader.**

GROUP LEADERS: Please collect, alphabetize and return the Health & Activity Records, Medication Forms, and Meningitis Response Forms (if applicable) for all campers in your group.

Check to make sure:

- The same Group and Leader Information is on all forms and that the correct Camp and Dates have been selected.
- Parent or guardian signature is on the Health and Activity Record.

2) **If camper is registered as an individual, please mail completed forms two or more weeks prior to arrival to:**

US MAIL

WOL Camp Registrar
P.O. Box 600
Schroon Lake, NY 12870

UPS OR FEDEX

WOL Camp Registrar
71 Olmstedville Road
Pottersville, NY 12860

If you are unable to meet the two-week deadline, the forms may be brought to camp and turned in at Registration.

STEP # 3 – Camp Preparation

- Medications:**
 - Medication must be in the original container.
 - Keep medication separate from luggage; all medications must be turned in at Registration and given to Camp Nurse upon arrival.
 - Campers with medications must be present at Registration to talk to one of the nurses and set up their medication schedule. Campers without medications should not come through the registration line.
 - Note: Campers may keep inhalers, creams, ointments and epi-pens, but must report those items to the nurse at Registration.
 - Health Screening – All campers will be screened in accordance with the “No-Nit” policy. Campers found with active cases of head lice will not be admitted to camp.

QUESTIONS: If you have any questions concerning the above, please contact the Health Center at 518-494-1423 or healthcenter@wol.org.



Word of Life Fellowship, Inc. Schroon Lake, NY 12870
HEALTH AND ACTIVITY RECORD

OFFICE USE ONLY Date received Completed Yes or No Nurse Initials
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INSTRUCTIONS: Print clearly. Please complete, sign, and date this form for all campers.
If coming with a Group, please give to Group Leader. If coming individually, please mail to Word of Life Camp Registrar, PO Box 600, Schroon Lake, NY 12870.

LAST NAME		FIRST NAME		MIDDLE INITIAL	Camp Attending <input type="checkbox"/> Snow Camp <input type="checkbox"/> Ranch <input type="checkbox"/> Island <input type="checkbox"/> Campus Days
DATE OF BIRTH		MALE	FEMALE	DATES ATTENDING CAMP	
		<input type="checkbox"/>	<input type="checkbox"/>		
List Church or Group and Leader Information below (if applicable)					
Church/Group Name, City & State:				Group Leader:	
Location and phone number where leader is staying during camp:					
Parent or Guardian	List Parent or Guardian's Full Name & Complete Address below			Telephone Numbers with Area Codes	
	Name:			Home: ()	
	Address:			Work: ()	
City: State: Zip Code:			Cell: ()		
IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES)				Telephone Numbers with Area Codes	
Name:				()	
Name:				()	
Are you covered by Medical Insurance? Yes No If yes, please complete insurance info at right and include copy of medical insurance cards (front and back)	Name of Company			Policy Number	
	Group Number			Telephone Number	
				()	
	Parent/Guardian Social Security Number (Required by Medical Facilities if under 18 years old)				
	Parent/Guardian Name:			Social Security No:	
ALLERGIC TO: <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Aspirin <input type="checkbox"/> Other					
ANY FOOD OR OTHER ALLERGIES? If yes, please explain.					

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

New York State Public Health Law requires Word of Life camps to maintain a completed Response Form for every camper who attends camp for seven (7) or more nights. (not applicable for weekends)

Check one box

- My child has had the meningococcal meningitis immunization (Menomune™) or (Menactra)
 Please circle one

Date received: _____

- 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.

camper's name _____

IF CAMPER HAS HAD OR CURRENTLY HAS ANY OF THE FOLLOWING PLEASE CHECK THE BOX AND INCLUDE YEAR OF OCCURRENCE:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Chronic Intestinal Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis or TB Contact | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Rubella (German) | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Operations |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Speech Defect | <input type="checkbox"/> Emotional Treatment |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Malaria |
| | | <input type="checkbox"/> Other _____ |

Able to Pursue All Normal Activities? If not explain: _____

Name of Family Physician or Medical Group: _____ Phone: _____

Name of Dentist or Orthodontist: _____ Phone: _____

- If camper has been immunized for any of the following, please attach proof of immunization OR provide dates for recommended vaccines below.

IMMUNIZATION HISTORY		1st Dose	2nd Dose	3rd Dose	4th Dose	Last Dose
Diphtheria & Tetanus (DTP, DTap, Pertussus, Td) Most recent dose should be within 10 years.						
Polio						
Note dates of actual diseases in section above.	MMR					
	Or Measles					
	Or Mumps					
	Or Rubella					
	Hepatitis B					
	Haemophilus Influenza B					
	Varicella (Chicken Pox)					

Early Departure Information: Campers needing to leave early must be picked up by parent (s) or guardian (s) who sign this form. Anyone other than the parent/guardian must have written permission signed by parent/guardian who has signed this form. The camp reserves the right to refuse dismissal without proper identification.

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 may include but are not limited to horseback riding, water sports, water skiing, skate park (if applicable), except as noted by me and the examining physician and has permission to leave the camp grounds for camp-related outings and purposes. I realize that my camper's picture and/or testimony may be used in the future promotion of Word of Life.

Word of Life Camps is a non-profit charitable organization dependent on God and His people. Those who use Word of Life's facilities and/or engage in related activities waive and release Word of Life Fellowship, 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. Word of Life 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 Name Here: _____

**Word of Life Camp
Individual Medication Order Form (Signature required by Physician)**

Last Name: _____ **First Name:** _____

The following may be administered to your child, if needed, while at camp. Physician's signature and approval is required.

Medication Order	Dosage	Physician Approval
		Please check Yes or No
Acetaminophen (Compared to active ingredient in Tylenol)	per label instructions by age/wt	Yes____ or No____
Ibuprofen (Compared to active ingredient in Advil)	per label instructions by age/wt	Yes____ or No____
DiphenhydramineHCl (Compared to active ingredient in Benadryl)	per label instructions by age/wt	Yes____ or No____
Guaifenesin usp (Compared to active ingredient in Robitussin)	per label instructions by age/wt	Yes____ or No____

Parents or guardians please list your child's prescription medications, vitamins, herbs and or dietary supplements, as ordered by the child's physician. Physician's signature is required for camp nurse to administer medication(s) to your child.

Medication Name	Route	Dosage	Frequency and Indications	Comments
Additional Physician orders:				

Signature of approving licensed health care provider authorized to prescribe medications.

Provider: _____ Date: _____

Print Name: _____ Title: _____

Phone number with area code: _____

If you have any questions concerning this form, call Word of Life Health Services at: 518-494-1423.

If you want the camp nursing staff to be able to administer even basic Tylenol to your child, you must have a Physician's signature on this form.