

## Important Medical & Health Notices

### MENINGOCOCCAL MENINGITIS IMMUNIZATION

New York State Public Health Law (NYS PHL) §2167 requires us to distribute information about meningococcal disease and vaccination to all campers. This law became effective on August 15, 2003.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, 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 meningitis among teens and young adults 15 to 24 years of age (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States - types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students.

To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information about the disease at New York State Department of Health Website: [www.health.state.ny.us](http://www.health.state.ny.us), or website of the Centers for Disease Control and Prevention (CDC): [www.cdc.gov/ncidod/d/bmd/disease/info](http://www.cdc.gov/ncidod/d/bmd/disease/info)

**Due to recent outbreaks of serious illnesses, Baiseinu can only accept campers and staff members who are fully up-to-date on their vaccinations.**

IMPORTANT NOTICE: The camp office MUST be notified if your child is exposed to any communicable disease during the three weeks prior to camp attendance.

If your child has a chronic or acute medical condition, it is imperative that the camp be notified. To speak to the camp nurse regarding confidential medical information regarding your child, please call our office to be directed to the EMT. All information will be held confidential.

# Parental Consent Form

**TO BE COMPLETED BY PARENTS**

Date of Birth \_\_\_\_\_

Present Age \_\_\_\_\_

CAMPER'S NAME \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Summer Phone # \_\_\_\_\_

Name of Bungalow Colony \_\_\_\_\_

In Emergency Call: Name \_\_\_\_\_

Phone # \_\_\_\_\_

Home Phone # \_\_\_\_\_

Father's Business # \_\_\_\_\_

Mother's Business # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

## **MEDICAL & PRESCRIPTION DRUG INSURANCE**

**Enclose copies of your Medical Insurance card & prescription drug coverage (if separate). If no cards are attached, you will be billed at regular drug store rates for all drugs, and you will be responsible for any additional medical costs.**

### **Insurance Information**

Company Name \_\_\_\_\_ Policy In The Name Of \_\_\_\_\_ Relationship \_\_\_\_\_

Group Name and Number \_\_\_\_\_ Identification Number \_\_\_\_\_

Other/Secondary Insurance Carrier & I.D. If Different From Above \_\_\_\_\_

Please detail any special circumstances or conditions that our medical or counseling staff should be aware of that will assist us in the care of your child (e.g. frequent colds, headaches, stomach aches, diarrhea, constipation, vomiting, bed-wetting, sensitivity to insect bites, homesickness, nightmares, anxiety reactions, etc.) and what you recommend as treatment:

## **DEPARTMENT OF HEALTH REGULATIONS REQUIRES THE FOLLOWING AUTHORIZATIONS FOR CHILDREN ATTENDING A SLEEP-AWAY CAMP:**

### **PARENTS' AUTHORIZATION**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

### **AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM PARENTS**

I/we, the undersigned, custodial parent(s)/guardian(s) of \_\_\_\_\_, a minor, do hereby authorize Camp Baiseinu, and/or Rabbi Chaim Luria, as our agent(s) to act in my/our name, place and stead in any way in 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 Catskill Regional Medical Center whether such diagnosis or treatment is rendered at the office of said physician or at Catskill Regional Medical Center. It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of 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 best judgment may deem advisable. This authorization shall remain effective until August 31, 2026, unless sooner revoked in writing delivered to said agent(s).

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

### **MENINGOCOCCAL MENINGITIS IMMUNIZATION**

My child has (I have):

- had the meningococcal meningitis immunization (Menomune™) within the past 10 years.  
Date received: \_\_\_\_\_ [Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]
- read, or have had explained to me, the information regarding meningococcal meningitis disease. My child (I) will obtain immunization against meningococcal meningitis within 30 days from my private health care provider.
- 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 (I) will not obtain immunization against meningococcal meningitis disease.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

### **TRIP/ACTIVITY AUTHORIZATION**

I hereby authorize Camp Baiseinu to take my child off camp grounds on trips organized as part of the program. This may include swimming and/or boating. My child may participate in any activity organized by Baiseinu, including but not limited to land sports, waterfront activities, indoor activities, bicycling, hiking, cook-outs etc. and I assume the inherent risk of such camp activities and camp programs. I will hold the camp harmless in the event of injury or property damage or loss as a result of such activities. I waive any and all rights to make a claim in case of injury or damage.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_