

April 28, 2010

Dear Parent or Guardian,

Enclosed is your Resident Camp Medical Packet. The packet includes:

- Letter to your child's doctor
- Letter to you about meningitis
- Information about meningitis from the New York State Department of Health
- State of New York law about meningitis
- Health Insurance Privacy Information
- Girl Health Examination Record (complete this form)
- Camper Confidential (complete this form)
- Medication Form (complete this form if your child requires medication)
- Meningococcal Meningitis Vaccination Response Form (complete this form)
- Asthma Form (complete this form only if your child has asthma)

A complete set of medical forms with all the pages filled out and the appropriate signatures and dates is **MANDATORY**. Your child will not be able to attend camp without it. If your child has not had a physical within 24 months of camp starting date, please make an appointment as soon as possible.

The first three pages are for the parents to complete. **You must sign the first page and provide copies of your insurance cards with the medical forms. If your child does not have medical insurance, note this on the form.**

The third page is the "Camper Confidential" which you complete. Two copies of the "Camper Confidential" are required. **The copy on the back of the booklet must be completed!** This copy will be filed in the Health Center. The second copy (which you can hand write on the enclosed form or photocopy the original) will be sent to your daughter's unit leader. The confidential form is very important. The information will help us better understand your child and her needs. Please be truthful and complete as possible.

The fourth has sections for PHYSICAL EXAMINATION and IMMUNIZATION HISTORY. The doctor completes this page or substitutes his /her standard office form.

The MEDICATION FORM has room to list any over the counter or prescription medications the camper will take at camp. On the back it has the list of over the counter medications we stock in camp. We cannot administer any medications without signatures from both the parent and a doctor. If your daughter has asthma, complete the Asthma Form. This information will help us to manage your child's asthma more effectively. *Emergency medications must be portable! Nebulizers that require electricity are not practical for many camp trips.* **Call the Camp Health Director if you have any questions. The doctor must sign, stamp and date the forms.**

The Meningococcal Meningitis Vaccination Response form is explained in a separate letter. Please complete it and return it with the other forms.

Please return all the medical forms as a set as soon as they are completed. **ALL FORMS MUST BE IN BY JUNE 1.** If your child's physical is scheduled after June 1 get the paperwork in as soon as possible. If they have had a physical within the last twenty-four months send in the paperwork with the old physical and send a copy of the latest one as soon as you have it. *Occasionally paper work is misplaced so please make a copy of all forms before you mail them. Bring these copies to check in just in case and keep it with you during your daughter's stay with us.*

**Rock Hill Camp tries to meet the needs of all its campers. If your child has special dietary or medical needs her paperwork must be in by June 1<sup>st</sup> and you must call me to ensure we can accommodate her needs!**

Upon arrival at Rock Hill, everyone will be examined for general physical condition and pediculosis (head lice). We will send home any person with any communicable disease such as Chicken Pox, or Measles. Please be considerate of other children and staff. All medication, including prescriptions, over-the counter and vitamins will be kept in the infirmary and dispensed as necessary by the staff. Our camp doctor is Putnam Valley Pediatric Associates PC and we use Putnam Hospital Emergency Room.

If you have any questions or concerns about your child and camp or the health paperwork leave a message for Jeanne Farrell at 845-452-1810 ext. 20. Your call will be returned within seven days. If you need immediate assistance, contact the operator who will direct your call.

If at any time during your child's stay at Rock Hill, you have any questions or concerns about your child's physical condition, a member of the Health Center Staff will be available to speak with you at 845-628-6611. We are a Resident Camp so if you call at an unusual time you will wake the staff. Please try to call between 9:30 am - 4:30 pm and 7 pm - 9 pm. Thank you for choosing Rock Hill Camp and it our hope that your child has a happy and healthy stay with us.

Sincerely,

*Jeanne M. Farrell*

Camp Director  
Rock Hill Camp  
845-452-1810 ext. 20

**Mail to:**

Girl Scouts Heart of the Hudson, Inc.  
2 Great Oak Lane  
Pleasantville, NY 10570

**or . . After June 20th**

Rock Hill Girl Scout Camp  
300 Wixon Pond Road  
Mahopac, NY 10541

Please write "Health Form – Rock Hill" on the outside of your envelope
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April 28, 2010

Dear Doctor:

Thank you for taking the time to provide us the important medical information we need to safely take care of our campers. This year's camp medical form is a four-page booklet plus separate pages for the medications, Meningococcal Meningitis Vaccination Response Form and asthma.

The first three pages of the "Girls' Health Examination Record" will be completed by the campers' parents. The fourth has sections for PHYSICAL EXAMINATION and IMMUNIZATION HISTORY. Each camper must have a Health Examination within twenty four months of his or her arrival at camp. You can complete this section of our form or attach your standard office form.

The MEDICATION FORM has room to list any over the counter or prescription medications the camper will take at camp. On the back it has the list of over the counter medications we stock in camp. We cannot administer any medications without signatures from both the parent and a doctor. There is a separate Asthma Form. If a camper has asthma this form must also be signed by both the parent and a doctor.

For SEVERE ALLERGIC REACTION following "section 3000-c of the Public Health Law permits camps to purchase and use epinephrine and auto-injector devices under the following conditions:

- such possession must pursuant to a collaborative agreement with an emergency health care provider, defined as a physician or a hospital
- any person who might use the device must have successfully completed a training course in the use of epinephrine auto-injector devices
- use of an epinephrine auto-injector device is covered by the Good Samaritan Act so long as you don't expect compensation from its use."<sup>\*</sup>

Our Epi-pen program is coordinated by Phelps Memorial Hospital Center. Select staff (RNs, EMTs, advanced first aiders) are trained at the beginning of the summer. "The course is taught according to the NYS DOH curriculum and provides certification good for one year."<sup>1</sup> Rock Hill Camp is located on 200 wooded acres in Mahopac, New York. Many of our older campers travel to wilderness areas in Massachusetts, New York, New Jersey and Pennsylvania. As you know, "a mild allergic reaction can escalate to anaphylactic shock in 1-2 minutes."<sup>\*\*</sup> Any time an Epi-pen is used the camper is immediately transported to the nearest emergency medical facility.

The separate page for the Meningococcal Meningitis Vaccination Response Form is completed by the parents but they will be looking to you for guidance. On July 22, 2003, the New York State Public Health Law was amended to include section 2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for 7 or more nights.

Sincerely,

*Jeanne M. Farrell*

Camp Director  
Rock Hill Camp

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<sup>1</sup> From the training material from Phelps Memorial Hospital Center

# GIRL SCOUTS HEART of the HUDSON - RESIDENT CAMP GIRL HEALTH RECORD

Name (Last, First, Initial)		Parent or Guardian			
Address		City	State	Zip	
Mom's Home ( ) _____	Dad's Home ( ) _____	Date of Birth		Age	Sex Female Male
Mom's Cell ( ) _____	Mom's Work ( ) _____				
Dad's Cell ( ) _____	Dad's Work ( ) _____				
Emergency Contact Person & Relationship to Camper (Not yourself, we always try parents/guardian first!)		Home Phone ( ) _____			
		Cell Phone ( ) _____			
		Work Phone ( ) _____			

**Allergies:**  No Known Allergies

- To foods (list):
- To medications (list):
- To the environment (insect stings, hay fever, etc. – list):
- Other allergies (list):

**Describe previous reactions:**

**Diet, Nutrition:**

- Eats a regular diet.  This camper eats a regular vegetarian diet.
- This camper has special food needs. **(Please describe below.)**

**Restrictions:**

- I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
- I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. **(Please describe below.)**

Is the participant covered by family medical/hospital/prescription insurance?    0 Yes    0 No

**Photocopy of front and back of all health insurance cards must be attached to this form.**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to engage in all prescribed activities, except as noted by me and/or the examining physician. I give permission to the physician selected by the camp and/or his designated associates to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Sian Here**

**Office Use Only**

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Office Use Only	
Insurance	
Parent Signature	
Med HX 6 <sup>th</sup> months	
Camper Confidential	
Immuno HX	
PE 2 Year	
MD Stamp & Signature	
Standing Order	
Meningitis Response	

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

- 1. Ever been hospitalized?  Yes  No
- 2. Ever had surgery?  Yes  No
- 3. Have recurrent/chronic illnesses?  Yes  No
- 4. Had a recent infectious disease?  Yes  No
- 5. Had a recent injury?  Yes  No
- 6. Had asthma/wheezing/shortness of breath?  Yes  No
- 7. Have diabetes?  Yes  No
- 8. Had seizures?  Yes  No
- 9. Had headaches?  Yes  No
- 10. Wear glasses, contacts, or protective eyewear?  Yes  No
- 11. Wear hearing aids or have hearing problems?  Yes  No
- 12. Had fainting or dizziness?  Yes  No
- 13. Passed out/had chest pain during exercise?  Yes  No
- 14. Had mononucleosis ("mono") during the past 12 months?  Yes  No
- 15. If female, have problems with periods/menstruation?  Yes  No
- 16. Have a problem with falling asleep/sleep walking?  Yes  No
- 17. Ever had back/joint problems?  Yes  No
- 18. Have a history of bedwetting?  Yes  No
- 19. Have problems with diarrhea/constipation?  Yes  No
- 20. Have any skin problems?  Yes  No
- 21. Traveled outside the county in the past 9 months?  Yes  No

**Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.**

# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has the camper:

- A. Ever been diagnosed with attention deficit disorder (ADD)?  Yes  No
- B. Ever been diagnosed with attention deficit hyperactivity disorder (ADHD)?  Yes  No
- C. Ever been treated for emotional or behavioral difficulties or an eating disorder?  Yes  No
- D. During the past 12 months, seen a professional to address mental/emotional health concerns?  Yes  No
- E. Had a significant life event that continues to affect the camper's life?  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others.)

**Please explain "Yes" answers in the space below, noting the number of the questions.**

**The camp may contact you for additional information.**

# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_

**GIRL SCOUTS HEART OF THE HUDSON, INC.**  
**CAMPER CONFIDENTIAL TO BE FILLED OUT BY PARENT OR GUARDIAN**

**Two copies of this page are required; one is kept with the medical records and one given to the Unit Staff.**

CAMPER'S FULL NAME: \_\_\_\_\_  
Last First Middle

GRADE IN FALL: \_\_\_\_\_ CAMP PROGRAM: \_\_\_\_\_

We earnestly desire to have our camp offer your child the happiest, most beneficial experience possible. Please answer the following questions regarding your child's interests and abilities.

1. Does your camper have any allergies (food, medication, insects, etc.)? \_\_\_\_\_
2. Does your child have asthma? \_\_\_\_\_
3. Does your camper have any food restrictions? \_\_\_\_\_
4. What is your child's eating habits? \_\_\_\_\_
5. Does your child have any fears? \_\_\_\_\_
6. No. of brothers \_\_\_\_\_ Ages \_\_\_\_\_ No. of sisters \_\_\_\_\_ Ages \_\_\_\_\_
7. What is your child's physical activity level? High \_\_\_\_\_ Medium \_\_\_\_\_ Low \_\_\_\_\_
8. Is your child easily frustrated? \_\_\_\_\_
9. How does your child express emotions? \_\_\_\_\_
10. What does sad look like? Frustrated? Mad? \_\_\_\_\_  
\_\_\_\_\_
11. How does your child respond to change? \_\_\_\_\_
12. Is your child sensitive to sight, sound or touch? \_\_\_\_\_
13. Would you characterize your child as flexible? \_\_\_\_\_
14. Is your child easily distracted? \_\_\_\_\_
15. What are your child's special abilities? \_\_\_\_\_
16. What are your child's hobbies? \_\_\_\_\_
17. Does your child wet the bed? \_\_\_\_\_

**Please repeat on this page any items from your camper's health history that her counselors should be aware of. Be sure to include asthma, allergies, seizure disorders, medications, learning disabilities, behavioral patterns, emotional sensitivities, restricted mobility and any other pertinent information.**

In what way did previous camp experience benefit your child? \_\_\_\_\_  
\_\_\_\_\_

What do you hope your child gains from her camp experiences this year? \_\_\_\_\_  
\_\_\_\_\_

Has any recent event affected your child in a way that might make her unhappy away from home? (such as death of a pet, parent away on long tip, impending or recent move, separation of parents, etc.) \_\_\_\_\_  
\_\_\_\_\_

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Relationship to camper: \_\_\_\_\_ Signature \_\_\_\_\_

**This Section to be filled in by physician after review of Health History with Parent/Guardian.  
Standard Physician office form may be substituted for this information.**

<p><b>Physical exam done today:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                  If "No", date of last physical: _____                  Must be within 24 months of the start of camp.                  Weight: _____ lbs Height: _____ ft _____ in                  Blood Pressure _____ / _____</p>	<p>Diet, Nutrition: <input type="checkbox"/> Eats a regular diet. <input type="checkbox"/> Has a medically prescribed meal plan or dietary restrictions: (describe below)</p>
<p>Allergies: <input type="checkbox"/> No Known Allergies  <input type="checkbox"/> To foods (list):  <input type="checkbox"/> To medications (list):  <input type="checkbox"/> To the environment (insect stings, hay fever, etc. – list):  <input type="checkbox"/> Other allergies (list):                  Describe previous reactions:</p>	<p><b>The camper is undergoing treatment at this time for the following conditions:</b> (describe below)  <input type="checkbox"/> None.</p>
<p><b>Medication:</b> <input type="checkbox"/> No daily medications. <input type="checkbox"/> Will take medications while at camp.                  Document these on the medication form.</p>	<p><b>Other treatments/therapies to be continued at camp:</b>                  (describe below) <input type="checkbox"/> None needed</p>
<p>Do you feel that the camper will require limitations or restrictions to activity while at camp? <input type="checkbox"/> No <input type="checkbox"/> Yes                  If you answered "Yes" to the question above, what do you recommend?                  (describe – attach additional information if needed)</p>	

**Immunization History:** Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please return with this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis* (DTap) or (Tdap)						xxxxxxxxxx
Tetanus booster* (dT) or (Tdap)	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	
Mumps, measles, rubella (MMR)			xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	
Polio (IPV)					xxxxxxxxxx	xxxxxxxxxx
Haemophilus influenzae type B (HIB)					xxxxxxxxxx	xxxxxxxxxx
Pneumococcal (PCV)					xxxxxxxxxx	xxxxxxxxxx
Hepatitis B				xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Hepatitis A			xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Varicella (chicken pox) <input type="checkbox"/> Had disease Date: _____			xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Meningococcal meningitis		xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx

**\*A Tetanus shot given within 10 years is required.**

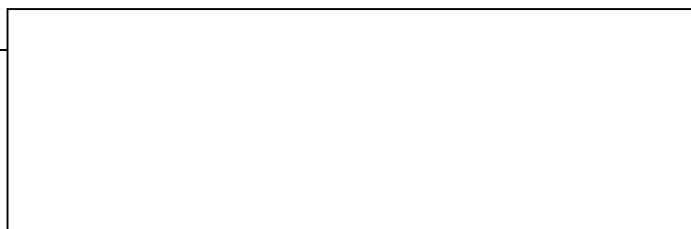
Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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The camp staff will treat SEVERE ALLERGIC REACTION such as insect stings, drug sensitivity, food reaction, etc. as follows: Determine the cause if possible. Call for medical assistance immediately. Administer Benadryl. See label for dosage by weight and age. If anaphylaxis is impending, due to severe allergic reaction and camper's weight is 66 lbs. or less, administer Epi-Pen Jr. If larger, use regular Epi-Pen. Transport to hospital by ambulance if available.

"I have reviewed the CAMPER HEALTH HISTORY FORM, and have discussed the camp program with the camper's parent/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Stamp with address and phone number



## Meningococcal Disease

### ***What is meningococcal disease?***

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord) caused by the meningococcus germ.

### ***Who gets meningococcal disease?***

Anyone can get meningococcal disease, but it is more common in infants and children. For some adolescents, such as first year college students living in dormitories, there is an increased risk of meningococcal disease. Every year in the United States approximately 2,500 people are infected and 300 die from the disease. Other persons at increased risk include household contacts of a person known to have had this disease, immunocompromised people, and people traveling to parts of the world where meningococcal meningitis is prevalent.

### ***How is the meningococcus germ spread?***

The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person.

### ***What are the symptoms?***

High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. The symptoms may appear 2 to 10 days after exposure, but usually within 5 days. Among people who develop meningococcal disease, 10-15% die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur.

### ***What is the treatment for meningococcal disease?***

Antibiotics, such as penicillin G or ceftriaxone, can be used to treat people with meningococcal disease.

### ***Should people who have been in contact with a diagnosed case of meningococcal meningitis be treated?***

Only people who have been in close contact (household members, intimate contacts, health care personnel performing mouth-to-mouth resuscitation, day care center playmates, etc.) need to be considered for preventive treatment. Such people are usually advised to obtain a prescription for a special antibiotic (either rifampin, ciprofloxacin or ceftriaxone) from their physician. Casual contact, as might occur in a regular classroom, office or factory setting, is not usually significant enough to cause concern.

### ***Is there a vaccine to prevent meningococcal meningitis?***

In February 2005 the CDC recommended a new vaccine, known as Menactra™ for use to prevent meningococcal disease in people 11-55 years of age. The previously licensed version of this vaccine, Menomune™ is available for children 2-10 years old and adults older than 55 years. Both vaccines are 85% to 100% effective in preventing the 4 kinds of the meningococcus germ (types A, C, Y, W-135). These 4 types cause about 70% of the disease in the United States. Because the vaccines do not include type B, which accounts for about one-third of cases in adolescents, they do not prevent all cases of meningococcal disease.

### ***Is the vaccine safe? Are there adverse side effects to the vaccine?***

Both vaccines are currently available and both are safe and effective vaccines. However, both vaccines may cause mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

### ***Who should get the meningococcal vaccine?***

The vaccine is recommended for all adolescents entering middle school (11-12 years old) and high school (15 years old), and all first year college students living in dormitories. However, the vaccine will benefit all teenagers and young adults in the United States. Also at increased risk are people with terminal complement deficiencies or asplenia, some laboratory workers and travelers to endemic areas of the world.

### ***What is the duration of protection from the vaccine?***

Menomune™, the older vaccine, requires booster doses every 3 to 5 years. Although research is still pending, the new vaccine, Menactra™, will probably not require booster doses.

### ***How do I get more information about meningococcal disease and vaccination?***

Contact your physician or your student health service. Additional information is also available on the websites of the New York State Department of Health, [www.health.state.ny.us](http://www.health.state.ny.us); the Centers for Disease Control and Prevention [www.cdc.gov/ncidod/diseases/index.htm](http://www.cdc.gov/ncidod/diseases/index.htm); and the American College Health Association, [www.acha.org](http://www.acha.org)

# STATE OF NEW YORK

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312--A

2003-2004 Regular Sessions

## IN SENATE

(Prefiled)

January 8, 2003

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Introduced by Sens. NOZZOLIO, LEIBELL, HANNON, LARKIN, DeFRANCISCO,  
FARLEY, HOFFMANN, MALTESE, PADAVAN, RATH, SKELOS, SPANO, VELELLA,  
VOLKER -- read twice and ordered printed, and when printed to be  
committed to the Committee on Health -- committee discharged, bill  
amended, ordered reprinted as amended and recommitted to said commit-  
tee

AN ACT to amend the public health law, in relation to information relat-  
ing to immunization against meningococcal meningitis

**The People of the State of New York, represented in Senate and Assem-  
bly, do enact as follows:**

1 Section 1. Statement of legislative findings and declaration of  
2 purpose. The legislature hereby finds and declares: meningococcal  
3 meningitis is a serious disease which can lead to death within only a  
4 few hours of onset, is fatal in one in ten cases, and leaves one in  
5 seven survivors with a severe disability such as loss of limb, cognitive  
6 deficits, paralysis, deafness, or seizures. The legislature further  
7 finds and declares that those residing in dormitory-like residences are  
8 at heightened risk to contract meningococcal meningitis and that chil-  
9 dren residing in camps share characteristics with populations which have  
10 been scientifically shown to be at heightened risk of exposure. The  
11 legislature further finds that meningococcal meningitis outbreaks cause  
12 significant alarm and confusion in the communities in which they occur.  
13 The legislature further finds and declares that the risk presented by  
14 meningococcal meningitis requires those individuals at risk to make an  
15 informed choice regarding immunization. The legislature further finds  
16 and declares that the educational and decision making processes  
17 warranted by meningococcal meningitis are not applicable to situations  
18 in which the risks require mandatory immunization.

19 § 2. The public health law is amended by adding a new section 2167 to  
20 read as follows:

EXPLANATION--Matter in **italics** (underscored) is new; matter in brackets  
[-] is old law to be omitted.

LBD01366-02-3

1 § 2167. Immunization against meningococcal meningitis. 1. As used in  
2 this section, unless the context requires otherwise:

3 a. The term "student" means a person attending an institution and, in  
4 the case of a student attending college, "student" means a person who is  
5 registered to attend or who attends classes at an institution, who is  
6 enrolled for at least six semester hours or the equivalent per semester,  
7 or at least four semester hours per quarter.

8 b. The term "institution" means an academy or college, as defined in  
9 section two of the education law, or a children's overnight camp as  
10 defined in section one thousand three hundred ninety-two of this chap-  
11 ter, where the person attending such camp remains overnight for a period  
12 of not fewer than seven days.

13 c. The term "immunization" means an adequate dose or doses of an  
14 immunizing agent against meningococcal meningitis which meets the stand-  
15 ards approved by the United States public health service for such  
16 biological products and which is approved by the department under such  
17 conditions as may be specified by the public health council.

18 2. Each institution shall distribute, in a form provided or approved  
19 by the commissioner, written information about meningococcal meningitis  
20 and meningitis immunization to all students. The information provided by  
21 the institution shall include, but not be limited to, the following:

22 a. a description of the disease and means of transmission;

23 b. the benefits, risks, and effectiveness of immunization;

24 c. the availability and cost of immunization, including an indication  
25 of whether or not the institution offers meningococcal meningitis immun-  
26 ization services.

27 3. Each institution shall also distribute, in a form provided or  
28 approved by the commissioner of health, a response form, to be completed  
29 by the student or, where the student is under the age of eighteen years,  
30 such student's parent or guardian, which shall include the following:

31 a. The student, or if under the age of eighteen years the parent or  
32 guardian of the student, certifies that the student has already received  
33 immunization against meningococcal meningitis within the ten years  
34 preceding the date of the response form;

35 b. The student, or if under the age of eighteen years the parent or  
36 guardian of such student, has received and reviewed the information  
37 provided by the institution, understands the risks of meningococcal  
38 meningitis and the benefits of immunization, and has decided that the  
39 student shall not obtain immunization against meningococcal meningitis.

40 The student, or if under the age of eighteen years the parent or guar-  
41 dian of such student, shall indicate his or her decision in a box or  
42 space placed appropriately on the form and shall return the completed  
43 form to the institution. Nothing in this subdivision shall be construed  
44 to prohibit an institution from incorporating the form required by this  
45 subdivision into another health certificate or form required by the  
46 institution.

47 4. Each institution shall maintain completed response forms.

48 5. No institution shall permit any student to attend the institution  
49 in excess of thirty days without complying with this section; provided,  
50 however, that such thirty day period may be extended to not more than  
51 sixty days if a student can show a good faith effort to comply with this  
52 section.

53 6. Nothing in this section shall be construed to prohibit institutions  
54 from adopting or maintaining more stringent policies regarding immuniza-  
55 tion against meningococcal meningitis.

56 § 3. This act shall take effect August 15, 2003.

**MENINGOCOCCAL**  
**MENINGITIS**  
**VACCINATION**  
**RESPONSE FORM**



**Girl Scouts®**

Girl Scouts Heart of the Hudson, Inc.  
www.girlscoutshh.org

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

**Check one box and sign below.**

- My child will not attend seven or more nights of overnight camp at Rock Hill this summer.
- My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: \_\_\_\_\_

[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™.]

- 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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent / Guardian)

Camper's Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Mailing Address: \_\_\_\_\_



Girl Scouts Heart of the Hudson, Inc.  
www.girlscoutshh.org

## GIRL SCOUT SUMMER CAMP MEDICATION FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

THIS FORM MUST INCLUDE ALL MEDICATIONS (over the counter and prescriptions) A CAMPER NEEDS TO BE GIVEN (including vitamins, salves, ointments, drops, etc.). The form and medication will be collected by the Camp Health Supervisor. Campers are NOT allowed to keep any medication in units. Any medication brought to camp WILL NOT be given unless this form has been COMPLETED.

This form must be signed by both the parent/guardian and a physician. A physician must sign this form even if your child is only taking over the counter medications!

MEDICATION NAME, DOSAGE & ROUTE	WHEN TAKEN (SPECIFIC TIMES)	FOR WHAT PURPOSE

The administration of this medication may be supervised by the Camp Director or Unit Leader if the Health Supervisor is unavailable: Yes ( ) No ( )

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

Stamp



## Girl Scout Camp Asthma Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### About Triggers

What triggers your asthma? Provide details about the triggers, including things the staff should be told.

- Exercise \_\_\_\_\_
- Fatigue \_\_\_\_\_
- Dehydration \_\_\_\_\_
- Stress \_\_\_\_\_
- Food Item \_\_\_\_\_
- Smoke \_\_\_\_\_
- Respiratory infections/Common cold \_\_\_\_\_
- Allergen \_\_\_\_\_
- Other \_\_\_\_\_

### Using a Peak Flow Meter

We recommend using a peak flow meter as a way to monitor your asthma and note signs of a potential flare before it is well established. **Please bring your peak flow meter to camp.**

When do you take peak flow readings?

- Breakfast  Lunch  Supper  Bedtime  Other \_\_\_\_\_

Routine peak flow reading (green zone) \_\_\_\_\_

Caution range (yellow zone) \_\_\_\_\_

What is done if the peak flow reading drops to the caution/yellow range? \_\_\_\_\_

Danger range (red zone) \_\_\_\_\_

What is done if peak flow reading drops to the danger/red zone? \_\_\_\_\_

### Nebulizer Treatment and Use

Will you bring a nebulizer to camp?  Yes  No

If yes, do you know when you need you nebulizer?  Yes  No

What medication is used via nebulizer? \_\_\_\_\_

### Administration of Medication

The administration of the medications may be supervised by the Camp Director or Unit Leader if the Health Supervisor is unavailable:  Yes  No

# About Medications

These medications are used daily to manage asthma.

Medication Name	Dose Given	When	Reason for Using this Medication

These medications are taken "as needed" to prevent an asthma flare.

Medication Name	Dose Given	When	Reason for Using this Medication

These medications are used when asthma flares.

Medication Name	Dose Given	When	Reason for Using this Medication

**Emergency medications must be portable! Nebulizers that require electricity are not practical for many camp trips. Call the Camp Health Director if you have any questions.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Parent / Guardian)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Physician)



Physician's Stamp

THIS FORM MAY BE SUBSTITUTED FOR THE MEDICATION FORM FOR ASTHMA MEDICATIONS. A Medication Form must be completed for all medications a camper needs to be given (including vitamins, salves, ointments, drops, etc.)

**GIRL SCOUTS HEART OF THE HUDSON, INC.  
2 GREAT OAK LANE  
PLEASANTVILLE, NY 10571  
914-747-3080**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT CAMPERS AND STAFF MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Girl Scout of Heart of the Hudson, Inc. (GSHH) is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to you PHI. GSHH is also required to abide by the terms of this Notice currently in effect.

*Uses and Disclosure of PHI Without Your Authorization.* GSHH is permitted to use PHI *without* your written authorization, or opportunity to object, in certain situations, including:

- For the health and safety of campers and staff,
- For the treatment, payment or health care operations activities of another health care provider who treats campers and staff;
- For health care member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence);
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military , national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance and workers' compensation law
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death or carrying on their duties as authorized by law;
- For research projects, but this will be subject to strict oversight and approvals;
- We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

(over)

*Patient Rights:* As a patient, you have a number of rights with respect to your PHI, including:

*The right to access, copy or inspect your PHI.* This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect and copy your medical information, you should contact our privacy officer.

*The right to amend your PHI.* You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact our privacy officer.

*The right to request an accounting.* You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used to disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you. We are not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting, contact our privacy officer.

*The right to request that we restrict the uses and disclosure of your PHI.* You have the right to request that we restrict how we use and disclose your medical information that we have about you. GSHH is not required to agree to any restrictions you request, but any restrictions agreed to by GSHH in writing are binding on GSHH.

*Revisions to the Notice:* GSHH reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities. You can get a copy of the latest version of this Notice by contacting our privacy officer.

*Your Legal Right and Complaints:* You also have the right to complain to us, or the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with the government or us. Should you have any questions, comments or complaints you may direct all inquiries to our privacy officer.

*Privacy Officer Contact Information*

Pam Makin  
Girl Scouts of Heart of the Hudson, Inc.  
2 Great Oak Lane  
Pleasantville, NY 10571  
914-747-3080