WORD OF LIFE HEALTH FORM INSTRUCTIONS

Dear Parent, Guardian, or Youth Leader:

On behalf of the Health Center staff at Word of Life Florida Youth Camp we would like to welcome you to camp! There are a few things you need to be aware of and help us with in order for our registration process to run smoothly on the first day of camp.

HEALTH FORM

• A Doctor's appointment is not necessary to complete this form.
• The Health and Activity Record (front and back) and the Medication Form must be completed in its entirety.
• One or both parents or guardian must sign this form.

MEDICATIONS

• All medication must be turned in at registration. Youth leaders and chaperones will not be permitted to administer medication to campers.
• Group leader – collect all medications from campers prior to check-in. Please have each camper's medications in Ziploc bags labeled with the camper's name. Collect and alphabetize health forms.
• All prescription medications need to be properly labeled and in the original pharmacy container for that specific camper. Do not mix medications.
• All medications need to be administered per doctor's order on the label. Any changes in dosage or schedule need to be authorized in writing by the camper's physician, and turned in with the medication at registration.
• **Camper must be able to administer his own injections**.

NOTE: Florida State law requires that all medications taken orally must be turned in. This includes: Tylenol, Midol, vitamins, cough syrup etc. in their original containers. Campers are allowed to keep their inhalers, Epi-pens, and medicated creams.

HEALTH SCREENING

• Word of Life camps have a "No Nits" policy. Active cases of head lice need to be treated adequately prior to camp admission. If a camper is found to be with head lice or nits he or she will be required to be treated and re-checked prior to admission to camp. Please inform your camper(s) not to share hairbrushes, hats or hair accessories.

(For a detailed description of our head lice policy, please download the info sheet from our website at www.wolflorida.org)

• Please make the nurse aware at registration of any special health concerns for your camper(s).

If you have any questions please contact Nurse Fran at 727-379-5034, 727-379-5680 or fringers@wol.org

Thank you for your cooperation in this matter.
Sincerely,
Word of Life Florida Youth Camp

Word of Life Florida Youth Camp ● 13247 Word of Life Dr ● Hudson, Fl 34669

CAMPER HEALTH AND ACTIVITY RECORD

Please complete, sign, and date this form for all campers. **PLEASE DO NOT MAIL.**

(If form is incomplete, parents or guardian will be contacted before camper is admitted to camp.) ***Please Print***

CAMPER LAST NAME (print below)	CAMPER FIRST NAME (print below)	CAMPER MIDDLE INITIAL

DATE OF BIRTH	AGE	MALE	FEMALE	DATES ATTENDING SUMMER CAMP
		☐	☐	

GROUP INFORMATION:	
Group Name:	**Leader Name:**
City:	**Leader's Cell Phone:**
Is Leader staying on campus during camp? ☐ **Yes** ☐ **No**	**Other Leader's Cell Phone:**

Parent Or Guardian Information		
	Parent/Guardian Name:	
	Address:	
	City:	**State:** **Zip code:**
	Home or Cell #: ( )	**Work #:** ( )
	Person picking up Camper at end of camp week Name (first/last) **& Cell number**	

IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES)	**Telephone Number w/ Area Code**
Name	( )
Relationship to Camper	

Family Health Insurance Information		
	Do you have Health Insurance? **YES** ☐ **NO** ☐ **If YES, please fill in the information below AND attach a copy of front and back of insurance card.**	
	Name of Company	Policy/Number
	Group Number	Telephone Number
		( )
	Parent/Guardian Name	

MEDICAL CONDITIONS

ALLERGIES: Does your child have any food/drug/environmental allergies? **YES** ☐ **NO** ☐ If yes please explain below

SPECIAL MEDICAL PROBLEMS, CONDITIONS OR RESTRICTIONS:

Is camper able to pursue all normal activities? **YES** ☐ **NO** ☐ If not explain below:

Name of Family Physician or Medical Group:	Phone:
Name of Dentist of Orthodontist:	Phone:

HEALTH HISTORY: If camper has had or currently has any of the following please check the box and include year of occurrence:

________	☐ Anemia	________	☐ Orthopedic Problems	________	☐ Seizures/Epilepsy
________	☐ Asthma	________	☐ Bed Wetting	________	☐ Diabetes:
________	☐ Chicken Pox	________	☐ Emotional Treatment	________	☐ Insulin Dependent
	☐ Kidney Problems		☐ Stomach Problems		☐ Non-Insulin Dependent

IMMUNIZATION HISTORY	1st Dose	2nd Dose	3rd Dose	4th Dose	Last
Diphtheria & Tetanus (DTP, DTap, Pertussus, Td) Most recent dose should be within 10 years.					
Polio Vaccine					
MMR					
Hepatitis B (or see waiver below)					
Haemophilus Influenza B					
Varicella (Chicken Pox)		**Please fill in the dates OR attach a copy of camper's Immunization record. Individuals will not be allowed to attend camp without complete immunization history or waivers.**			
Meningococcal Meningitis (or see waiver below)					
Other (please specify)					

Meningitis & Hepatitis B Immunization WAIVERS: Please check and sign below for each waiver if you have chosen NOT to have your child immunized for Meningitis and/or Hepatitis B.

Meningitis Vaccination Waiver:

☐ I have (my child has) read, or have had explained to me information regarding meningococcal meningitis disease (attached). I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease. ☐ Check here if child is not old enough to receive vaccine (first dose recommended age 11-12).

Signature of Parent or Guardian:____**Date:**_______________

Hepatitis B Vaccination Waiver:

☐ I have (my child has) read, or have had explained to me information regarding Hepatitis B disease (attached). I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signature of Parent or Guardian:____**Date:**_______________

RESPONSE AND CONSENT (required):

- The health and immunization history is correct so far as I know.
- Those who use Word of Life's facilities and/or engage in related activities, waive and release Word of Life Fellowship from any claim for personal injury or property damage. I understand that I am financially responsible for all medical cost(s) incurred while my child is at camp.
- My child has permission to engage in all prescribed camp activities, including horseback riding, 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.
- I hereby give my permission to release information to the designated youth leader with my child during this week of camp.
- 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 understand that all medicines, vitamins, etc. must be given to the camp nurse upon arrival and that they must be in the original containers. I understand that the camp nurse is not authorized to give injections of any kind and that my child must be able to administer his own injections if needed.
- 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. I give permission for my child to be transported to area medical facilities by the camp's vehicles and drivers in non-emergency health situations.
- This form may be photocopied for use out of camp.

Signature of Parent or Guardian:____**Date:**_______________

Word of Life Florida Youth Camp - Individual Medication Form

(Parents, please fill out and sign at the bottom of the page)

Camper Last Name:_________________________ **Camper First Name:**______________________

The following may be administered to your child, if needed, while at camp. **You do not need to bring these since these medications are available at camp.**

Medication	Dosage	Approval Please check Yes or No
Acetaminophen (Compared to active ingredient in **Tylenol**)	per label instructions	YES ☐ NO ☐
Ibuprofen (Compared to active ingredient in **Advil**)	per label instructions	YES ☐ NO ☐
Diphenhydramine HCI (Compared to active ingredient in **Benadryl**)	per label instructions	YES ☐ NO ☐
Guaifenesin (Compared to active ingredient in **Robitussin** or **Mucinex**)	per label instructions	YES ☐ NO ☐
Bismuth subsalicylate (Compared to active ingredient in **Pepto Bismol**)	per label instructions	YES ☐ NO ☐
Calcium Carbonate Antacid (Compared to active ingredient in **Tums**)	per label instructions	YES ☐ NO ☐
Hydrocortisone cream 1% for itching/rash	per label instructions	YES ☐ NO ☐

- Parents or guardians, please list your child's prescription medications, over the counter medications, vitamins, herbs and/or dietary supplements below.
- **ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINERS.**
- **PRESCRIPTION MEDICATIONS MUST HAVE THE CAMPER'S NAME AND CORRECT DOSAGE ON THE BOTTLE OR A NOTE FROM THE DOCTOR IF OTHERWISE.**
- **THE CAMPER MUST BE ABLE TO ADMINISTER HIS / HER OWN INJECTIONS.**

Medication Name	Route (oral, injection, etc.)	Dosage	Frequency and Indications	Comments
Additional Physician orders:				

Parent Signature ____ Date ____________________

Rev. 9/2017

Meningococcal Disease

Florida State Department of Health Bureau of Communicable Disease Control

Information for College Students and Parents of Children at Residential Schools and Overnight Camps

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).

Who gets meningococcal disease?

- Anyone can get meningococcal disease, but it is more common in infants and children. For some college students, such as freshmen living in dormitories, there is an increased risk of meningococcal disease. Between 100 and 125 cases of meningococcal disease occur on college campuses every year in the United States; between 5 and 15 college students die each year as result of infection. Currently, no data are available regarding whether children at overnight camps or residential schools are at the same increased risk for disease. However, these children can be in settings similar to college freshmen living in dormitories. 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 meningitis is prevalent.

How is the germ meningococcus spread?

- The meningococcus germ is spread by direct close contact with nose or throat discharges of an infected person. Many people carry this particular germ in their nose and throat without any signs of illness, while others may develop serious symptoms.

What are the symptoms?

- High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. 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.

How soon do the symptoms appear?

- The symptoms may appear 2 to 10 days after exposure, but usually within 5 days.

What is the treatment for meningococcal disease?

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

Is there a vaccine to prevent meningococcal meningitis?

- Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause about 70% of the disease in the United States.

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

- The vaccine is safe, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days.

What is the duration of protection from the vaccine?

- After vaccination, immunity develops within 7 to 10 days and remains effective for approximately 3 to 5 years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

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

- Contact your family physician or your student health service. Additional information is also available on the websites of the Florida State Department of Health, www.floridahealth.gov ; the Centers for Disease Control and Prevention www.cdc.gov and the American College Health Association, www.acha.org.

Hepatitis B Disease

Florida State Department of Health Bureau of Communicable Disease Control

Information for College Students and Parents of Children at Residential Schools and Overnight Camps

What is Hepatitis B?

- Hepatitis B is a serious infection that affects the liver. It is caused by the hepatitis B virus. Each year about 2,000-4000 people die in the United States from cirrhosis or liver cancer caused by hepatitis B.

Hepatitis B can cause:

Acute (short term) illness. This can lead to:

- Loss of appetite
- Tiredness
- Pain in muscles, joints and stomach
- Dirarrhea and vomiting
- Jaundice (yellow skin or eyes)

Chronic (long term) illness. Some people go on to develop chronic hepatitis B infection that can lead to liver damage (cirrhosis), liver cancer or death. Chronic infection is more common among infants and children than adults. People who are chronically infected can spread hepatitis B virus to others, even if they don't look or feel sick. Up to 1.4 million people in the United States may have chronic hepatitis B infection.

How is hepatitis B spread?

The hepatitis B virus is easily spread through contact with the blood or other body fluids of an infected person. People can also be infected from contact with a contaminated object, where the virus can live for up to 7 days.

- A baby whose mother is infected can be infected at birth.
- Children, adolescents and adults can become infected by
  - contact with blood and body fluids through breaks in the skin such as bites, cuts or sores
  - contact with objects that have blood or body fluids on them
  - having unprotected sex with an infected person
  - sharing needles when injecting drugs
  - being stuck with a used needle

Why get vaccinated?

- Hepatitis B vaccine can prevent hepatitis B and the serious consequences of hepatitis B infection, including liver cancer and cirrhosis. Hepatitis B vaccine may be given by itself or in the same shot with other vaccines. Vaccination gives long-term protection from hepatitis B infection, possibly life-long.

Who should get vaccinated?

- Children and adolescents normally get 3 doses of hepatitis B vaccine: 1st dose at birth or later, the 2nd dose 1-2 months after the first dose, and the 3rd dose 6-18 months after the first dose.
- All unvaccinated adults at risk for hepatitis B infection should be vaccinated. For a list of risk factors, see your health professional. Adults should get 3 doses of the vaccine – with the second dose given 4 weeks after the first dose, and the third dose given 5 months after the first dose.

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

- Hepatitis B vaccine is a very safe vaccine. Most people do not have any problems with it. The vaccine contains non-infectious material and cannot cause hepatitis B infection. Some mild problems have been reported: soreness where the shot was given (up to about 1 person in 4), Temperature of 99.9 or higher (up to about 1 person in 15). Severe problems are extremely rare. Severe allergic reactions are believed to occur about once in 1.1 million doses.
- Signs of a serious reaction can include a very high fever or behavior changes, hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.
- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor can file this report, or you can do it at www.vaers.hhs.gov or by calling 1-800-822-7967.

Who should not get hepatitis B vaccine?

- Anyone with a life-threatening allergy to yeast, or to any other component of the vaccine, should not get hepatitis B vaccine. Tell your doctor if you have any severe allergies.
- Anyone who has had a life-threatening allergic reaction to a previous dose of hepatitis B vaccine should not get another dose.
- Anyone who is moderately or severely ill when a dose of vaccine is scheduled should probably wait until they recover before getting the vaccine.
- Note: you might be asked to wait 28 days before donating blood after getting the hepatitis B vaccine. This is because the screening test could mistake vaccine in the bloodstream (which is not infectious) for hepatitis B infection.

How do I get more information about hepatitis B disease and vaccination?

- Contact your family physician or your student health service or your local health department. Additional information is also available on the websites of the Florida State Department of Health: www.floridahealth.gov,; the Centers for Disease Control and Prevention www.cdc.gov and the American College Health Association, www.acha.org.