ЮН

МПЗ-2011

КАРТА ЗГОЛОШЕННЯ **ЮНАЦТВА**

6-го серпня – 13-го серпня 2011 р.

на пластовій оселі " ВОВЧА ТРОПА"

*ТЕРМІН ЗГОЛОШЕНЬ: **15 кбітня 2011 р.***

На табір: ☐ ПРИХИЛЬНИКІВ ☐ УЧАСНИКІВ ☐ РОЗВІДУВАЧІВ ☐ СКОБІВ і ВІРЛИЦЬ

Вже здобув потрібний пластовий ступінь ____ ТАК ____НІ

Як ні, пластовий ступінь отримаю (Дата) ________________

Ім"я і прізвище (латинкою)	Ім"я і прізвище (українською)	Дата Народження
		ММ/ДД/РІК

Адреса	Телефон	Стать
		Х Д
	E-mail	

Пластова станиця	Пластовий курінь	Пластовий гурток

Розмір сорочки (Adult) : S M L XL XXL

Бажана прогулька (*для учасників*):

☐ мандрівна

або

☐ роверова

*Привезу свій ровер та шолом ____ **ТАК** ____ **НІ***

Кількість місць на КОЖНУ з прогульок є ОБМЕЖЕНА, проте спробуємо догодити всім!

Бажана прогулька (*для розвідувачів*):

☐ мандрівна

або

☐ канойкарська

Вмію плавати: ___Дуже добре ____ Задовільно ____ Не вмію

Підпис юнака/юначки ______________________________ Дата______________

Я, дозволяю моєму синові/моїй дочці стати учасником МПЗ-2011:

Підпис ____ Дата ____________

БЕЗ ПІДПИСУ ЗВЯЗКОВОГО/ СТАНИЧНОГО ЗГОЛОШЕННЯ НЕ ДІЙСНЕ!

Я, зв'язковий/станичний зголошеного юнака/зголошеної юначки рекомендую його/її стати учасником МПЗ-2011:

Підпис ____

Дата ________ *E-mail*__________________________________

Медичне забезпечення Прошу долучити копію страховки

Carrier ____

Policy # ______________________________ Group # ______________________

Carrier Address

____

Залучую:

1. Оплату в розмірі **$450** дол.; чек виписаний на: ***Plast - USO***
2. Копію страховки
3. Meningococcal disease information
4. Emergency Contact/Медична карта

Зголошення та чек надсилати на:
Plast - MPZ 2011
(ЮН)
P.O. Box 34184
Parma, OH 44134

!!!Після 15 квітня — оплата **$550 амер. дол.!!!**

PARENTS' AUTHORIZATION FOR FIELD TRIPS

I am aware that the Plast MPZ program may include several field trips and that these field trips may involve any or all of the following activities: crossing state boundaries, travel by bus, swimming, canoeing, mountain biking and overnight stay outside of Plast Camp property. Understanding the above, I hereby give my child permission to participate in these field trips. ***WITHOUT A SIGNATURE, CHILD WILL NOT ATTEND THE FIELD TRIP.***

______________________________________ ______________________

Signature of Parent or Guardian for Field Trips **Date**

PHOTOGRAPH RELEASE FORM

I understand and give permission that my child may be photographed during Plast MPZ functions and these photographs may be placed on the Plast USA website, used in a jamboree DVD or used in Plast promotional material.

______________________________________ ______________________

Signature of Parent or Guardian for photo release **Date**

February 1, 2011

MENINGOCOCCAL DISEASE

Dear Parent,

On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §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. This law became effective on August 15, 2003.

Vovcha Tropa is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent /guardian;
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningitis, a potentially fatal bacterial infection, 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. 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 teens and young adults. Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at www.meningitisvaccine.com. I encourage you to carefully review the enclosed materials.

To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information about the disease at the New York State Department of Health website: WWW.HEALTH.STATE.NY.US, and the website of the Center for Disease Control and Prevention (CDC), WWW.CDC.GOV/NCIDOD/DBMD/DISEASEINFO.

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

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.

You must CHECK ONE BOX, sign below and return this form.

☐ My child has 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.]

☐ 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 (print):____

Date of Birth: ______________

Signed: ____ **Date:** ______________

(Parent/Guardian/Camper if 18 years or older)

PLAST MPZ 2011
EMERGENCY CONTACT FORM

Camper's Name___________________________________ D.O.B._____________

Home Address ___________________________________ Height ____________

____Weight____________

Home Phone ____________________________________ Eye Color__________

Parents' Names __________________________________ Hair Color_________

ATTACH THIS SIZE PHOTOGRAPH OF CAMPER HERE.

Telephone	Mother's	Father's
HOME		
CELL		
WORK		
EMAIL		

In case of emergency, parents will be called first, if they are unable to be contacted, list in order of priority other persons to be called:

1. Name____ Relationship to camper _______________________

Day Phone ( )_________________Evening Phone ( )____________________Cell Phone ( )_______________

2. Name____ Relationship to camper _______________________

Day Phone ( )_________________Evening Phone ( )____________________Cell Phone ( )_______________

3. Name____ Relationship to camper _______________________

Day Phone ( )_________________Evening Phone ( )____________________Cell Phone ( )_______________

МПЗ 2011

МЕДИЧНА КАРТА **ПРОСИМО ДОКЛАДНО ДРУКОМ ВИПОВНИТИ.**
HEALTH HISTORY FORM **PLEASE PRINT CLEARLY.**

(This side to be filled by parents/guardian of minors or by adult campers/staff members themselves.)

Name ____ Birth date ____________ Sex ______ Age _________
Last First Initial

Parent or Guardian (or Spouse) ____

Home Address ____ Home Phone _____________________
Street & Number City State ZIP Area/Number

Business Phone ___________________________________ Cell Phone ______________________ Email ____________________________
Area/Number Area/Number

Second Parent or Guardian or Emergency Contact ____

Home Address ____ Phone __________________________
Street & Number City State ZIP Area/Number

Business Phone ___________________________________ Cell Phone ______________________ Email ____________________________
Area/Number Area/Number

It not available in an emergency, notify

Name ____Relationship _______________________________

Address ____ Home Phone ___________________ Cell __________________
Street & Number City State ZIP Area/Number Area/Number

Do you carry family medical/hospital insurance? _______ Yes ______ No ***PLEASE ATTACH COPY OF INSURANCE CARD.***

If so, indicate: Carrier _____________________ Policy # _____________________________Group # ____________________________

Carrier Address ____

Operations or serious injuries *(dates)* ____
____
Chronic or recurring illness or medical condition ____
____
Dietary restrictions____
Current medications – please record on ***Medication Form*** ____
Other diseases ____
Name of dentist/orthodontist ____ Phone_____________________________
Name of family physician ____ Phone_____________________________
Suggestions on health related information for camp personnel ____
____
For Female
Has this person menstruated? ___________ If not, has she been told about it? ____
If so, is her menstrual history normal? ___________ Special Consideration ____

Important -- This Box Must be completed for Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer ____ Date ______________

I also understand and agree to abide with the restrictions placed on my camp activities.
Signature of minor or adult camper/staffer ____ Date ______________

Health Care Recommendations by Licensed Physician

Height __________ Weight __________ Blood Pressure ______________

The applicant is under the care, of a physician for the following condition(s):

____

I have examined: (Name of Camper)

____

Date Examined _______________________

In my opinion, the above camper's condition, ___does _____does not preclude his/her participation in an active camp program.

Current treatment – please record on ***Medication Form***____

Explanation of any reported loss of consciousness, convulsion, or concussion

____

____

Does applicant have epilepsy? ☐ Yes ☐ No Does applicant have diabetes? ☐ Yes ☐ No

Recommendations and Restrictions while at Camp

Any treatment to be continued at camp? ____

____

Any medication to be administered at camp? ☐ Yes ☐ No **If yes, please record on *Medication Form***

Any medically - prescribed meal plan or dietary restrictions?

____

ALLERGIES: ***(food, drugs, plants, insects, etc.)*** ____

____

Activities to be encouraged or limited

____

Additional health information

____

Immunization History (Copy of immunization history may be included)

Health History

(Check: Give approximate dates.)

__________ Frequent Ear Infections
__________ Heart Defect/Disease
__________ Convulsions
__________ Diabetes
__________ Bleeding/Clotting Disorders
__________ Hypertension
__________ Mononucleosis Diseases
__________ Chicken Pox
__________ Measles
__________ German Measles
__________ Mumps

Allergies (Dates not needed)

__________ Hay Fever
__________ Ivy Poisoning. etc.
__________ Insect Stings
__________ Penicillin
__________ Other Drugs
__________ Asthma
__________ Other *(Specify)*
____

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) } Tetanus DPT* or		
Tetanus TD* Diphtheria or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given ________(most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		
Meningococcal Meningitis		
Varicella		

Licensed Physician's Signature

____

Address ____ Phone ____________________

Street & Number City State ZIP Area/Number

Date of Form Completion ________________________ *By ______________________________

**Initial if completed by nurse or physician's assistant*

Individualized Orders for: **Camper's Name: _____________________________D.O.B.__________**

МПЗ 2011 MEDICATION FORM ***as required by Columbia County, NY Dept. of Health***

Physician's Name: ____ Phone ________________________

Physician's Address: ____ License # _______________________

Physician's Signature ____Date ____________________________

STANDARD OVER THE COUNTER/PRN MEDICATIONS: (The following medications may be available in the infirmary and will be administered at the discretion of the RN, ***ONLY IF approval is indicated with a check mark below by the camper's physician***).

DRUG NAME / ROUTE	INDIC-TIONS	CHECK MEDS CAMPER CAN RECEIVE	OTHER INDICATIONS	DRUG NAME / ROUTE	INDIC-TIONS	CHECK MEDS CAMPER CAN RECEIVE	OTHER INDICATIONS
Advil Cold & Sinus PO	As directed on package			Imodium AD PO	As directed on package		
Bacitracin ointment TOPICAL	As directed on package			Junior Strength Tylenol PO	As directed on package		
Benadryl (caps. & elixir) PO	As directed on package			Maalox Tabs & Liquid PO	As directed on package		
Burn Jel TOPICAL	As directed on package			Milk of Magnesia PO	As directed on package		
Caladryl Lotion TOPICAL	As directed on package			Pepto Bismol (tabs & liquid) PO	As directed on package		
Chloroseptic Throat Spray PO	As directed on package			Refresh Eye Drops OPTHALMIC	As directed on package		
Children's Advil Suspension &/or chewable – PO	As directed on package			Regular Strength Tylenol PO	As directed on package		
Child. PediaCare Nightrest PO	As directed on package			Robitussin CF PO	As directed on package		
Children's Tylenol suspension &/or chewable – PO	As directed on package			Triaminic Cold & Cough PO	As directed on package		
Claritin PO	As directed on package			Tylenol Allergy Sinus PO	As directed on package		
Dimetapp Cold & Allergy PO	As directed on package			Tylenol Sinus PO	As directed on package		
Eye irrigating solution OPTHALMIC	As directed on package			Tylenol Sore Throat PO	As directed on package		
Hydrocortisone Cream 1% TOPICAL	As directed on package			Vicks Nyquil PO	As directed on package		
Ibuprofen PO	As directed on package				As directed on package		

PRESCRIPTION MEDICATIONS:

DRUG NAME	ROUTE	DOSAGE	INDICATIONS	COMMENTS