

Onteora Scout Reservation

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. 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.

Onteora Scout Reservation 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 or guardian; AND
- 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 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 have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

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. **Please complete the Meningococcal Vaccination Response Form on the reverse side of this letter as part of your child's Summer Camp health form.**

To learn more about meningitis and the vaccine, please contact and/or 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.

Sincerely,
Donald J. Smith
Reservation Director
Onteora Scout Reservation

Onteora Scout Reservation

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

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 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.

Signed: _____ Date: _____
(Parent / Guardian)

Camper's Name: _____ Date of Birth: _____

Mailing Address: _____

Parent/Guardian's E-mail address (optional): _____

CATSKILL REGIONAL MEDICAL CENTER
AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR
TEMPORARILY SEPARATED FROM PARENT/GUARDIAN

I/We, the undersigned, custodial parent(s)/guardian(s) of _____,
(Print name of minor)
a minor, do hereby authorize _____,
(Print name of camp or facility)

or any authorized representative thereof, 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.

With respect to consent to diagnostic procedures or medical care, 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 my/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/her best judgment may deem advisable.

This authorization shall remain effective until _____, 2____, unless sooner revoked in writing and delivered to said agent(s).

(Signature of custodial parent or guardian) (date)

(Signature of custodial parent or guardian) (date)

(Witness) (date)

Custodial Parent(s)/Guardian(s) Contact Information

Name: _____

Permanent Address: _____

Temporary Address: _____

Phone numbers: Home: () ____ - ____ Work: () ____ - ____ Mobile: () ____ - ____

Insurance Carrier/Plan: _____ Policy/I.D.#: _____

Insurance company address/phone #: _____

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD

