

CAMPER HEALTH HISTORY FORM

If your camper has special dietary or medical needs please contact us at 800-474-1912 or info@girlscoutcsa.org BEFORE coming to camp.

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last
Birthdate: _____ Age on arrival at camp: _____
Month/Day/Year

Check-in Screening: Date: _____ Temp _____ Initials _____
Head Check: _____ Signs or Symptoms of Illness: _____
Updates to Health History? _____
Medications? _____
 Exit Note: Left Camp with no reported illness injury
 Left Camp with the following concerns: _____
Person notified: _____ Date: _____ Time: _____

Camper Name _____
First _____
M.I. _____
Last _____
(For Camp Use) Unit _____
(For Camp Use) Session _____

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____
Preferred Phones: (_____) _____ (_____) _____
Email: _____
Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____
Preferred Phones: (_____) _____ (_____) _____
Email: _____
Additional contact in event parent(s)/guardian(s) cannot be reached:
Name: _____ Relationship to Camper: _____
Preferred Phones: (_____) _____ (_____) _____

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper 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)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No
Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.
Insurance Company _____ Policy Number _____
Subscriber _____ Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp 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. I give permission to photocopy this form. 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.

Signature of Custodial Parent/Guardian _____ Date _____ Relationship to Camper _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

CAMPER HEALTH HISTORY FORM 1

Camper Name: _____ Birthdate: _____
 First M.I. Last Month/Day/Year

Immunization History: Please attach a copy of camper's immunization record to this form.

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian _____ Date _____ Relationship to Camper _____

Permission for non-prescription medications:

The following non-prescription medications are commonly stocked in the Camp Health Center and are used on an **as needed** basis to manage illness and common minor injuries. **Cross out** any medication your camper should **NOT** have:

- | | |
|--|---|
| Benadryl/Diphenhydramine (reaction to insect bites/stings) | Tylenol/Acetaminophen (aches, pains, slight fever) |
| Calamine lotions/Cortaid/Hydrocortisone (poison ivy) | Ibuprofen (aches, pains, slight fever) |
| Betadine (antiseptic) | Mylanta/Tums (upset stomach) |
| Neosporin/Triple Antibiotic ointment | Throat lozenges (sore throat) |
| Immodium/Loperamide (diarrhea) | Aloe (burns) |
| Decongestant/Phenylephrine (allergies/stuffy nose) | Orajel (toothache) |
| Ear Dri (water in the ears) | Multi symptom menstrual relief (for cramps and discomfort from periods) |

CAMPER HEALTH HISTORY FORM 1

Camper Name: _____ Birthdate: _____
 First M.I. Last Month/Day/Year

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

Has/does the camper:

- | | |
|---|---|
| 1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Had mononucleosis during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with periods/menstruations? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have problems falling asleep/sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Ever had back/joint problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have a history of bedwetting? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have problems with diarrhea/constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Have any skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Anxiety or Depression? <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Been treated for self-harm/suicidal thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Wears glasses, contacts or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Traveled outside the country in the past 9 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Has the camper:

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
- Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
- During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
- 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.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (____) _____
 Name of dentist(s): _____ Phone: (____) _____
 Name of orthodontist(s): _____ Phone: (____) _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.