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)
Calamine lotions/Cortaid/Hydrocortisone (poison ivy)
Betadine (antiseptic)
Neosporin/Triple Antibiotic ointment
Immodium/Loperamide (diarrhea)
Decongestant/Phenylephrine (allergies/stuffy nose)
Ear Dri (water in the ears)

Tylenol/Acetaminophen (aches, pains, slight fever)
Ibuprofen (aches, pains, slight fever)
Mylanta/Tums (upset stomach)
Throat lozenges (sore throat)
Aloe (burns)
Orajel (toothache)
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?	☐Yes	☐No	12. Had fainting or dizziness?	☐Yes	☐No
2. Ever had surgery?	☐Yes	☐No	13. Passed out/had chest pain during exercise?	☐Yes	☐No
3. Have recurrent/chronic illnesses?	☐Yes	☐No	14. Had mononucleosis during the past 12 months?	☐Yes	☐No
4. Had a recent infectious disease?	☐Yes	☐No	15. Have problems with periods/menstruations?	☐Yes	☐No
5. Had a recent injury?	☐Yes	☐No	16. Have problems falling asleep/sleepwalking?	☐Yes	☐No
6. Had asthma/wheezing/shortness of breath?	☐Yes	☐No	17. Ever had back/joint problems?	☐Yes	☐No
7. Have diabetes?	☐Yes	☐No	18. Have a history of bedwetting?	☐Yes	☐No
8. Had seizures?	☐Yes	☐No	19. Have problems with diarrhea/constipation?	☐Yes	☐No
9. Had headaches?	☐Yes	☐No	20. Have any skin problems?	☐Yes	☐No
10. Anxiety or Depression?	☐Yes	☐No	21. Been treated for self-harm/suicidal thoughts?	☐Yes	☐No
11. Wears glasses, contacts or protective eyewear?	☐Yes	☐No	22. Traveled outside the country 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.***

Has the camper:
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .... ☐Yes ☐No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? .... ☐Yes ☐No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? .... ☐Yes ☐No
4. 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.