girl scouts of southern nevada

Girl Scout Camp - Health and Medical History

- ✓ The information on this form helps us provide the best care for your child; withholding, misrepresenting or incomplete information may be grounds for dismissal. Notify camp staff if there are changes to this form.
- ✓ A medical exam is required **only if** the camper has had surgery, serious illness, an injury that has limited her activity, or has been hospitalized in the last year.
- ✓ All medications (prescription, over the counter and supplements) brought to camp must be listed on this form and in their original container.

Office use only:

Camper name: _____ _____ _____
Last First MI

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone:_____Birthdate: _____

Age at start of camp:_____Grade entering in the fall: _____

Camper lives with: ☐Mother ☐Father ☐Both: Together ☐Both: Separately ☐Other: _____

1st Parent's/Guardian's Name: _____

Home Phone:_____Work Phone:_____Cell Phone: _____

2nd Parent's/Guardian's Name: _____

Home Address (if different from above): _____

Home Phone:_____Work Phone:_____Cell Phone: _____

Additional Contacts – *If the above are not reachable in case of camper illness/behavior contact,*

1. Name:_____Relationship to Camper: _____
   Home Phone:_____Work Phone:_____Cell Phone: _____
2. Name:_____Relationship to Camper: _____
   Home Phone:_____Work Phone:_____Cell Phone: _____

Insurance Information – Is the participant covered by family medical/hospital insurance? ☐Yes ☐ No

Carrier/Plan Name:_____Group #: _____

Carrier Address: _____

Name of Insured:_____Relationship to Participant: _____

Insurance ID Number: _____

Medical Treatment at Camp:

The following over-the-counter medications are used at camp under the discretion of our Camp Health Team.
Cross out any products that you do not want your child to have.

☐ I give permission for the following medications to be administered for common ailments:

Tums	Lip Balm	Advil	Bee sting swabs	1% hydrocortisone cream
Tylenol	Liquid cough suppressant	Cough Drops	Aloe Vera gel	Benadryl, 25mg & cream
Anbesol	Sudafed decongestant	Sunscreen	Pepto-Bismol	Antibiotic cream

Authorization to Provide Necessary Treatment or Emergency Care

I hereby give permission to medical personnel selected by the camp director to order x -rays, routine tests, or other treatment; to release any records necessary for insurance purposes; to release a diagnosis and prescription to camp staff; and to provide or arrange any necessary related transportation for my child. If I cannot be contacted, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization. This completed form may be photocopied for trips out of camp. Both sides of this form are correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted on this form.

Parent/Guardian Signature * _____ Print Name_____ Date_____

**if for religious reasons you cannot sign, contact camp for a waiver that must be signed for attendance.* (please complete both sides of this form)

Health History

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts, eyewear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems? (e.g. itching, rash, acne)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleepwalking?	☐	☐
25. If female, have an irregular menstrual history?	☐	☐
26. Have a history of bed-wetting?	☐	☐
27. Have an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐
29. Have ADD or ADHD?	☐	☐
30. Had a physical exam in the past year?	☐	☐
31. Traveled abroad in the past month?	☐	☐

Explain any "yes" answers, noting the number of the questions and any other medical treatment received.

_____

_____

Allergies (Medication, food, other) Reaction and management of reaction

_____ _____

_____ _____

Please provide additional information about the participant, include general behavior; physical, emotional, or mental health; activities child should be exempt from for medical reasons; and dietary or other restrictions.

_____

_____

Immunizations – give month/year of the last immunization/booster, or attach a copy of the official record:

_____ Tetanus _____ Measles/Mumps/Rubella _____ Hepatitis A _____ Meningitis

_____ Chicken Pox _____ Diphtheria/Pertussis (DtaP/DT) _____ Hepatitis B _____ Other

Medications

Identify medications taken during school year that participant is not taking at camp:

_____

List all medications brought to camp. **Attach additional paper as necessary**. Keep medications in original packaging; prescription original packaging must identify the prescribing physician, medication name, dosage, and frequency of administration. Please call in advance if medications or dosage have changed in the past three months.

☐ This person takes medication as follows ☐ This person takes NO routine medication

Med #1:_____ Reason for taking_____Side effects_____

Time:_____Dosage:_____ Time:_____Dosage:_____

Time:_____Dosage: _____ Time:_____Dosage: _____

Med #2:_____Reason for taking_____Side effects _____

Time:_____Dosage:_____ Time:_____Dosage:_____

Time:_____Dosage: _____ Time:_____Dosage: _____

Family Physician & Contact Info _____

Family Dentist & Contact Info_____