

# 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.
- ✓ This form is for health center use; information important for your camper's Camp Guide to know should be repeated on the Letter to My Child's Camp Guide.

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: \_\_\_\_\_

1<sup>st</sup> Parent's/Guardian's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

2<sup>nd</sup> 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.

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

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

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**Allergies** (Medication, food, other)

Reaction and management of reaction

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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.

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**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 \_\_\_\_\_

## Camper Release Form

This document identifies people who are authorized to pick-up and/or be contacted regarding the below-named child. Persons listed on this form are understood to be contacts for camp to use while the camper is in the care of camp, and able to be contacted to pick-up the camper as needed (due to behavior, illness, or at the end of the session). The person dropping off/picking up the child must sign this form at camp, and a camp staff member must witness the signature. Only authorized adults listed on this sheet may pick up children from camp. Photo identification will be required at pick up, for your child's safety.

Please notify Girl Scouts if there are any changes 702-385-3677.

### Campers Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### Camper lives with:

Both Parents  Mother  Father  Guardian  Foster Parents

I authorize the following adults to pick-up my camper from camp as necessary should they need to leave camp early due to illness, injury, or behavior, and at the end of the session. I have informed them that they are listed here and might be contacted.

Girl Scouts of Southern Nevada will only release campers to adults listed here regardless of their relationship to the camper or being listed on another form. Therefore, please make sure to list all appropriate guardians, parents, relatives, and friends. Please be attentive to when your camper's session ends and have an adult listed here scheduled to pick her up.

Name	Relationship to Camper	Day Phone	Cell/Evening Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The above-listed people have my permission to pick-up my child from Girl Scouts of Southern Nevada.

I hereby give permission to Girl Scouts of Southern Nevada to arrange any necessary program-related transportation for my child (e.g. specialty camp day-trip transportation). A 15 passenger van driven by a Girl Scout staff member will be utilized to transport campers from Frias Frontier to their adjacent Camper Cabins.

Parent or Guardian (Print Name) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/2021

## A Letter to My Child's Camp Guide

**To be completed by camper's parent/guardian.** This letter will go directly to the camper's camp guide. Any information for the health center staff should be on the Health and Medical History form.

Dear Camp Guide,

This is \_\_\_\_\_ 's \_\_\_\_\_  
(#) year at an overnight camp.

I want my camper to go to camp because \_\_\_\_\_

While at camp, I hope my camper will \_\_\_\_\_

My Girl Scout is most happy when \_\_\_\_\_

most unhappy when \_\_\_\_\_

enthusiastic about \_\_\_\_\_

not fond of \_\_\_\_\_

tends to be afraid of \_\_\_\_\_

allergic to \_\_\_\_\_

is poor fair good excellent at person hygiene (brushing teeth, changing dirty clothes, hand washing); and is poor fair good excellent at taking care of personal belongings.

My Girl Scout gets along with other Girl Scouts who \_\_\_\_\_

At home my Girl Scout can be challenging with \_\_\_\_\_

My Girl Scout has the following responsibilities at home \_\_\_\_\_

Please pay special attention to \_\_\_\_\_

Has this camper been diagnosed as having a learning disability, emotional or behavior problem? Yes/ No  
If yes, please explain (this letter will be given directly to the camp guide and used to help us provide the best possible experience for your Girl Scout. If the health staff or Camp Director should be aware of these needs please include them on the Health and Medical History form) \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_

## A Letter to My Camp Guide

To be completed by camper.

Dear Camp Guide,

My name is \_\_\_\_\_ . My friends call me \_\_\_\_\_ .

I have \_\_\_\_\_ brother(s), age(s) \_\_\_\_\_, and \_\_\_\_\_ sister(s), age(s) \_\_\_\_\_ .

I live with (please circle); Mom Dad Brother(s) Sister(s) Other \_\_\_\_\_ .

In my spare time, I like to \_\_\_\_\_

\_\_\_\_\_

When I'm not in school, the things I like to do least are \_\_\_\_\_

\_\_\_\_\_

I am good at \_\_\_\_\_

\_\_\_\_\_

I am coming to Frias Frontier Girl Scout Camp because \_\_\_\_\_

\_\_\_\_\_

I hope to be able to do the following things at camp this summer \_\_\_\_\_

\_\_\_\_\_

When I'm at camp, I don't want to \_\_\_\_\_

\_\_\_\_\_

I get along with friends who \_\_\_\_\_

\_\_\_\_\_

Last summer, I \_\_\_\_\_

\_\_\_\_\_

Next year I will be in \_\_\_\_\_ grade at school.

Camper's Signature \_\_\_\_\_