Day Camp Camper Health History- Girl Scouts of Northern California

first last

Camper Name _____ Dates attending camp_____
Address _____
Phone Number _____ Birth date _____ Age at camp _____
Troop # _____ School attending in fall _____
Parent/Guardian #1 Name_____
Daytime Phone _____ Alternate/Cell Phone _____
Parent/Guardian #2 Name _____
Daytime Phone _____ Alternate/Cell Phone _____
Emergency Contact Other than Parents/Guardians _____
Daytime Phone _____ Alternate/Cell Phone _____
Doctor's Name _____ Phone Number_____

Please check all of the illnesses/injuries/conditions that have occurred in the past 6 months:

___Asthma
___Allergies
___Attention deficit disorder
___Bleeding/clotting disorder
___Braces
___Chest pain
___Chicken Pox
___Diabetes
___Ear Infection
___Fainting
___Frequent headaches
___Head injury
___Hearing loss
___Heart Defect/Disease
___Hospitalization
___Hypertension
___Joint injury
___Learning disability
___Lyme disease
___Mononucleosis
___Motion sickness
___Muscle injury
___Seizures
___Skeletal injury
___Surgery
___Vision difficulties/wears glasses

Please provide explanations for any checked boxes.

_____

Allergies- Please list all known and describe reaction.

Allergies to medication:
_____ Reaction _____
_____ Reaction _____
Allergies to food:
_____ Reaction _____
_____ Reaction _____
Other Allergies:
_____ Reaction _____
_____ Reaction _____

Medications- Medications to be taken during camp need to be brought to camp in their original container accompanied by signed instructions from parent/guardian including dosage and time taken. **Please list medications being taken on a regular basis and the reason.**

Prescription Medications:
_____ Reason _____
_____ Reason _____
Over the Counter Medications:
_____ Reason _____
_____ Reason _____

*****The camp will have sunscreen, bug spray, and some basic over the counter medicine for first aid needs. Please indicate permission for your camper to receive the following basic first aid and health treatments by checking below:**

Sunscreen _____ **Topical Anti-Itch Cream (for bug bites/minor rashes) ____**
Bug Spray _____ **Topical Anti-Bacterial cream (for minor cuts or scrapes) _____**
Non-Asprin pain reliever (such as Tylenol or Ibuprofen) _____
Upset Stomach medicine (such as Pepto Bismol or Tums) _____

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Name _____ Unit or Group _____ Date of Birth _____

Name

Unit or Group

Date of Birth

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Please list any restrictions to food or activity for your child.

_____

_____

Please share any other information you feel the camp staff should have about your child's physical, emotional, or mental health.

_____

My child's racial background is: (Please check all that apply.)
___ Black or African American ___ Hawaiian or Pacific Islander ___ American Indian or Alaskan Native
___ White ___ Asian ___ Other
My child's ethnic background is:
___ Hispanic or Latino ___ Not Hispanic or Latino

Immunization History- Please give the most recent dates for the following immunizations.
___ I have chosen **not** to immunize my child.

Vaccine:	Mo/Yr	Mo/Yr	Vaccine:	Mo/Yr	Mo/Yr
Polio	_____	_____	DTP	_____	_____
MMR	_____	_____	T/D(tetanus/diphtheria)	_____	_____
Or Measles	_____	_____	Tetanus	_____	_____
Or Mumps	_____	_____	Haemophilus influenza B	_____	_____
Or Rubella	_____	_____	Hepatitis B	_____	_____
			Varicella	_____	_____

My child has had: ___Chicken Pox ___Measles
___Mumps ___German Measles ___Hepatitis A ___Hepatitis B ___Hepatitis C

Health Information and Privacy Statement:
The Day Camp Health History is for health care concerns at the specified events only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the sponsoring council until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

My signature below indicates:
I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission for my child to receive emergency medical treatment as needed. My child may participate in all camp activities unless otherwise noted. All information given is complete and accurate to the best of my knowledge.

Parent/Guardian Signature _____ Date _____

Photo Release: I hereby give consent for my camper to appear in photographs taken and used by Girl Scouts of Northern California and its assigns or successors, in Girl Scout publication(s)/media and whatever ways they may desire, including audiovisual productions, television and electronic transmissions; furthermore, I hereby consent that such photographs and plates from which they are made shall be the property of the Photographer, and the Girl Scouts shall have the right to duplicate, reproduce and make other uses of such photographs and plates for Girl Scout publicity and publications as they may desire free and clear of any claim whatsoever on my part. The Photographer will not sell the photos without permission of the Girl Scouts of Northern California I am of legal age, have the right to contract for the minor, and freely sign this release, which I have read and understood.

Parent/Guardian Signature _____ Date _____

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