Girl Scouts –Totem Council

Community Camp Health History

This form must be filled out by a parent/legal Guardian of the camper. The information on this form will remain confidential. Please print in blue or black ink.

Mail this form to this address by **June 1**
Kayak Community Camp
c/o Donna Derby
2915 -99th Ave. NE
Lake Stevens WA 98258

*Important; **It is your responsibility to inform us of changes to your child's health status.***

Camper Name (last) ________________________(first)________________________________ Date of Birth ___/ ___/___ Age at Camp _______

Address ____ City________ Zip_______ Phone ( )_________________

Emergency Contacts – Must include Parent/Guardian or person completing form

Name	Relationship	Day Phone	Evening Phone
		( )	( )
		( )	( )
		( )	( )

In case of emergency:Physician'sname/phone#____ Dentist's name/phone # ________________________________

Insurance Carrier or Plan Name ___________________________Subscriber's Name________________________ Group ID#______________________

Chronic illness
(check and specify)
❑ Heart disease
❑ Asthma
❑ Rheumatic fever
❑ Sickle cell anemia
❑ Diabetes
❑ Tuberculosis
❑ Epilepsy/seizures
❑ Other (specify)
____

Diseases
❑ Eating Disorder
❑ Mononucleosis
❑ Emotional disturbance
❑ Recent Infections:
____
❑ Other (specify)
____

Other health conditions
(check all that apply)
❑Frequent colds
❑ Stomach upsets
❑ Constipation/diarrhea
❑ Menstrual cramps
❑ Motion sickness
❑ Wears glasses
❑Wears contact lenses
❑ Bed wetting
❑ Sleep walking
❑ Frequent headaches
Kidney trouble
❑ Hearing impairment
❑ Frequent sore throats
❑ Frequent ear infections
❑ Pediculosis (lice)
❑ Nosebleeds
❑ Night terrors
❑ Fainting
❑ Other (specify)
____

Allergies – List all Known

	Reaction or symptoms	Management or Treatment
Medication allergies		
Food allergies		
Other allergies (include insect stings, hay fever asthma, animal dander, etc.)		

Attach separate sheet if necessary

Please explain care and treatment of any items checked above. Indicate any information useful to camp staff in relation to these health conditions. ________________________
____

Describe any current health conditions or complicating medical problems requiring medication, treatment, special restrictions while at camp, or in the event of an emergency.
____
____

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Immunization History

Are the required school immunizations up to date? ❑ Yes ❑ No Hepatitis A ❑ Yes ❑ No Chicken Pox Disease ❑ Yes ❑ No Chicken Pox Vaccine ❑ Yes ❑ No

Date of last tetanus shot ________________ Other (mo/year) __________________________ disease __________________________________

Is your daughter currently:

❑ receiving psychological counseling
❑ under a physician's care
❑ taking prescription medication
❑ taking over the counter medication
❑ taking no medication on a routine basis
❑restricted in physical activity

In the last year, has your daughter had:

❑ an injury/illness requiring medical attention
❑ a surgical operation or fracture
❑ restrictions from participation in physical education
❑ an illness lasting longer than 5 days
❑hospital treatment
❑ exposure to contagious disease

Please explain any items checked above ____

____

List past medical treatment such as operations, treatment for serious injuries, diseases or disabilities, hospitalizations and dates. ______________________________

____

Has your daughter been instructed in the menstrual cycle? Yes ❑ No ❑ begun menstruation? Yes ❑ No ❑

Any medical or dietary regimen to be followed? ____

Prescription medications or orthodontic appliances being brought to camp (be sure to label each item with child's name): ______________________________

Explain any restrictions to activities; what cannot be done, what adaptations or limitations are necessary? ______________________________________

____

Any emotional disturbances or behavior problems? ____

____

This health history is complete and accurate. I know of no reason(s) other than the information indicated on this form, why my daughter should not participate in strenuous activities such as swimming, horseback riding, and hiking except as noted: ____

This box must be completed for attendance. * If for any religious reason you cannot sign this, contact the registrar for the alternate form.

Authorization and Consent to Treatment

I attest that (camper's name) ______________________________is in good health and able to actively participate in camp activities except as noted on this form. I understand that camping programs involve inherent risk and possible injury because of the nature of the activity, even when conducted in a safe manner. I authorize all routine health care, surgical, diagnostic and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital, when efforts to contact me are unsuccessful and when deemed immediately necessary by the physician to safeguard my child's health. I waive my right of informed consent to such treatment.

Signature of Parent/Legal Guardian X____ **Date**______________________

Print Name ____ **Relationship to Camper** __________________________________

In our continuing effort to assure that our program is open to all, we collect data on the girls we serve. Your cooperation in providing this information is deeply appreciated. Please indicate how your daughter identifies her racial/ethnic background by checking all boxes that apply.

❑ (B) African American/Black ❑ (AI) American Indian/Alaskan Native ❑ (AS) Asian/Pacific Islander ❑ (H) Spanish/Hispanic ❑ (W) White ❑ (O) Other ______________________