

Day Camp Camper Health History- Girl Scouts of Northern California

Camper Name first _____ last _____ 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:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Lyme disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Attention deficit disorder	<input type="checkbox"/> Head injury	<input type="checkbox"/> Motion sickness
<input type="checkbox"/> Bleeding/clotting disorder	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Muscle injury
<input type="checkbox"/> Braces	<input type="checkbox"/> Heart Defect/Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Skeletal injury
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Surgery
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Joint injury	<input type="checkbox"/> Vision difficulties/wears glasses
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Learning disability	

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) _____

Day Camp Health History- Girl Scouts of Northern California

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.

Table with 6 columns: Vaccine, Mo/Yr, Mo/Yr, Vaccine, Mo/Yr, Mo/Yr. Rows include Polio, MMR, Or Measles, Or Mumps, Or Rubella, DTP, T/D(tetanus/diphtheria), Tetanus, Haemophilus influenza B, Hepatitis B, and 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.

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.

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.

Parent/Guardian Signature _____ Date _____

Name

Unit or Group

Date of Birth