

# CAMP HEALTH HISTORY AND EXAMINATION FORM

Girl Scout Council of Nation's Capital

Name: \_\_\_\_\_  
 Camp Name: \_\_\_\_\_  
 Session: \_\_\_\_\_  
 Program: \_\_\_\_\_  
 \*Keep this form for your own records\*

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**PARENT/GUARDIAN #1**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #1: \_\_\_\_\_

Phone #2: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

**PARENT/GUARDIAN #2**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone #1: \_\_\_\_\_

Phone #2: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #1: \_\_\_\_\_

Phone #2: \_\_\_\_\_

Phone #3: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

**Allergies**  No Known Allergies  Drug  Food  Contact/Environment

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Health Care Providers**

Primary: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

Covered by medical/hospital insurance?  Yes  No

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group/ID: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

**Immunization History** Are all immunization up-to-date?  Yes  No

- Immunizations are recorded below, with dates that basic immunizations were completed as well as dates of most recent booster doses  
 School immunization form is attached

	Primary Series	Last Booster	Primary Series	Last Booster
DTaP	_____	_____	MMR	_____
DPT	_____	_____	Measles	_____
DT	_____	_____	Mumps	_____
TDAP	_____	_____	Rubella	_____
TD	_____	_____	Varicella	_____
Hepatitis B	_____	_____	HIB	_____
Hepatitis A	_____	_____	PVC	_____
OPV, IPV (Polio)	_____	_____		_____

Tuberculosis Screening TST: Last Date \_\_\_\_\_ Result \_\_\_\_\_

If immunizations are not up to date, including the DPT, please submit a state certificate from physician or parent stating medical or religious reason. If your child is under 5 years old and is not currently in school full time, please attach a copy of their immunization record.

**Dietary Restrictions** Please specify any accommodations needed.

Vegetarian  Vegan  Kosher  Halal  Allergy  Other

\_\_\_\_\_  
 \_\_\_\_\_

**Health History** Check "Yes" or "No" for each statement. Explain "Yes" answers below and explain any accommodations needed.

- |   |  |  |
|---|--|--|
| 1. Asthma?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                        | 12. Sleeping disorder/sleep walking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Physical disability?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| 2. Diabetes?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                      | 13. Urinary tract infections?..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | 24. Visual disability?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 3. Seizures/epilepsy/convulsions?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Heart defect/disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | 25. Deaf/hard of hearing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                    |
| 4. Frequent ear infections?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | 15. Bleeding/clotting disorders?..... <input type="checkbox"/> Yes <input type="checkbox"/> No     | 26. Behavioral problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| 5. Frequent colds/sore throat?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | 16. Hypertension..... <input type="checkbox"/> Yes <input type="checkbox"/> No                     | 27. Psychiatric counseling/hospitalizations?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Sinusitis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                     | 17. Recent infectious disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | 28. Eating disorder?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                         |
| 7. Bronchitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No                     | 18. Chronic/recurring illness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No       | 29. Has this person menstruated?..... <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| 8. Fainting/dizziness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | 19. Skin conditions?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 | 30. If not, has she been told about it?..... <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| 9. Stomach upsets?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                | 20. ADD/ADHD?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                        | 31. If so, is her menstrual history normal?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 10. Constipation/diarrhea?..... <input type="checkbox"/> Yes <input type="checkbox"/> No        | 21. Emotional disability?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            | 32. Operations or serious injuries?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| 11. Bed wetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | 22. Learning disability?..... <input type="checkbox"/> Yes <input type="checkbox"/> No             | 33. Other diseases?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          |

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**AUTHORIZATION**

This health history is correct so far as I know. The person herein described has my permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*If for religious reasons you can not sign this form, then submit a legal waiver which must be signed for attendance.

# HEALTH EXAMINATION BY LICENSED PHYSICIAN

Girl Scout Council of Nation's Capital - Resident Camp

Please have your child's primary healthcare  
provider complete this form and fax it to

**202-274-2161**

\*Keep the original copy for your own records\*

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_

Camp Name: \_\_\_\_\_  
Session: \_\_\_\_\_  
Program: \_\_\_\_\_

*This part to be completed by Physician. **Must be signed for participation.** Please use additional sheet of paper if needed.*

I have examined the above camper within the past year. Date of Examination: \_\_\_\_\_

In my opinion, the above's conditions  **DOES** /  **DOES NOT** preclude her participation in an active camp program.

**Physical Exam** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

**This applicant is under the care of a physician for the following conditions:** \_\_\_\_\_

\_\_\_\_\_

**Current treatment(s) and/or medications(s):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Explanation of any reported loss of consciousness, convulsion, or concussion:** \_\_\_\_\_

\_\_\_\_\_

**Does camper have epilepsy or seizures?**  YES /  NO If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**Will the camper need to bring an Epi-Pen?**  YES /  NO If yes, explain and complete Specialized Health Care Services  
Needed At Camp form: \_\_\_\_\_

\_\_\_\_\_

**Will the camper need to bring an asthma inhaler?**  YES /  NO If yes, explain and complete Specialized Health Care  
Services Needed At Camp form: \_\_\_\_\_

\_\_\_\_\_

**Any other condition(s) that camp nurse or staff should be made aware?**  YES /  NO If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**Recommendations and/or restrictions while at camp?** List any treatment to be continued at camp: \_\_\_\_\_

\_\_\_\_\_

**Any medically prescribed meal plan or dietary restrictions?** \_\_\_\_\_

\_\_\_\_\_

**Additional information or activity restrictions?** \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Name of Licensed Physician

\_\_\_\_\_  
Licensed Physician's Signature

Date Form Completed: \_\_\_\_\_

By \_\_\_\_\_

(\*Initial if completed by nurse or physician's assistant)

# INSURANCE INFORMATION

Girl Scout Council of Nation's Capital - Resident Camp

Please attach a copy of the FRONT  
and BACK of your insurance card to  
this form and fax it to

**202-274-2161**

Name: \_\_\_\_\_

Camp Name: \_\_\_\_\_

Date of Birth : \_\_\_\_\_

Session: \_\_\_\_\_

Age: \_\_\_\_\_

Program: \_\_\_\_\_

## FRONT OF INSURANCE CARD

## BACK OF INSURANCE CARD

# MEDICATIONS/TREATMENT TO BE ADMINISTERED AT CAMP

Girl Scout Council of Nation's Capital - Resident Camp

Please have your child's primary healthcare provider complete this form and fax it to

**202-274-2161**

\*Keep the original copy for your own records\*

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_

Camp Name: \_\_\_\_\_  
Session: \_\_\_\_\_  
Program: \_\_\_\_\_

1. By law all prescription medications must be brought to camp in their original containers, with the doctor's instructions. DO NOT pre-dispense, place in a daily pill holder, wrap in outer materials, or ask us to dispense by other than doctor's orders. Do not bring expired medications. Medications not in original containers will not be held or dispensed at camp.
2. A physician must sign this form authorizing any prescription and over-the-counter medications listed below.
3. All prescription medicines must be in original container with pharmacy label with prescription number, date filled, prescribing physician's name, name of medication, directions for use, and the patient's name. All Over-the-Counter medications must be in original container should have the campers name written on the box.
4. At least one dose of a prescription medicine MUST be given to camper at home before bringing to camp.
5. Medicine times are directly after breakfast, lunch and before dinner and at bedtime, unless otherwise directed.
6. Please indicate if medicine is taken daily or as needed.
7. You must be specific with any variations or conditions associated with "as needed".
8. If your daughter will need to bring an inhaler, Epi-Pen, or other emergency medication to camp, please complete the Specialized Health Care Services form.

The Health Center stocks the following over-the-counter medication at camp which are used on an as needed basis to manage illness and injury. Please cross out those the camper should NOT be given.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Acetaminophen (i.e. Tylenol)                                   | <input type="checkbox"/> Guaifenesin cough syrup (i.e. Robitussin plain) | <input type="checkbox"/> 0.5% hydrocortisone cream            |
| <input type="checkbox"/> Ibuprofen (i.e. Advil, Motrin)                                 | <input type="checkbox"/> Saline nose drops                               | <input type="checkbox"/> Medcaine Swabs                       |
| <input type="checkbox"/> Diphenhydramine antihistamine/allergy medicine (i.e. Benadryl) | <input type="checkbox"/> Antibiotic cream (i.e. Bacitracin)              | <input type="checkbox"/> Anbesol Gel                          |
| <input type="checkbox"/> Cepacol Sore Throat Spray                                      | <input type="checkbox"/> Anti-fungal cream (i.e. Tinactin)               | <input type="checkbox"/> Tums / Chewable Pepto Bismal Tablets |
| <input type="checkbox"/> Mucinex plain  | <input type="checkbox"/> Absorbine Jr aspirin free analgesic ointment    |   |
|   | <input type="checkbox"/> Calamine/Caladryl Lotion                        |   |

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Phone: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

# SPECIALIZED HEALTH CARE SERVICES NEEDED AT CAMP

Girl Scout Council of Nation's Capital - Resident Camp

Please have your child's primary healthcare provider complete this form and fax it to

**202-274-2161**

\*Keep the original copy for your own records\*

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_

Camp Name: \_\_\_\_\_  
 Session: \_\_\_\_\_  
 Program: \_\_\_\_\_

## ALLERGY ACTION PLAN Allergy to: \_\_\_\_\_

### SYMPTOMS

### GIVE CHECKED MEDICATION

- If a food allergen has been ingested, but no symptoms: .....  EpiPen  Antihistamine
- Mouth Itching, tingling, or swelling of lips, tongue, mouth: .....  EpiPen  Antihistamine
- Skin Hives, itchy rash, swelling of the face or extremities: .....  EpiPen  Antihistamine
- Gut Nausea, abdominal cramps, vomiting, diarrhea: .....  EpiPen  Antihistamine
- Throat = Tightening of throat, hoarseness, hacking cough: .....  EpiPen  Antihistamine
- Lung = Shortness of breath, repetitive coughing, wheezing: .....  EpiPen  Antihistamine
- Heart = Thready pulse, low blood pressure, fainting, pale, blueness: .....  EpiPen  Antihistamine
- Other.....  EpiPen  Antihistamine
- If reaction is progressing (several of the above areas affected), give: .....  EpiPen  Antihistamine

### DOSAGE

Epinephrine: Inject intramuscularly EpiPen OR EpiPen Jr (circle one)

Antihistamine: Give \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.  
medication name dose route

Other: Give \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.  
medication name dose route

- Camper has permission to carry her own Epi-Pen and has been instructed in proper use.
  - I prefer counselors carry my daughter's Epi-Pen with the understanding it will be available to her at all times.
- EMS will be always be called if epinephrine is given whether or not the camper manifests any symptoms of anaphylaxis.*

## ASTHMA ACTION PLAN Triggers: \_\_\_\_\_

Name of Medication and Strength: \_\_\_\_\_ Type of Device: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Times(s) Medication is Given: \_\_\_\_\_ Time Interval for Repeating Dose: \_\_\_\_\_  
 \_\_\_\_\_

If camper is taking more than one medication, list sequence in which medications are to be taken:  
 \_\_\_\_\_  
 \_\_\_\_\_

Camper has permission to carry her inhaler with her and has been instructed in proper use.  Yes  No

- I understand that I must supply the camp with the equipment/supplies listed above.
- I hereby authorize the treatment/procedures described above to be administered by Camp Health Care Staff
- I understand that I and/or my physician will be called if a question arises about my daughter's procedure

Parent/Guardian Signature: \_\_\_\_\_  
 Parent/Guardian Phone: \_\_\_\_\_  
 Physician's Signature: \_\_\_\_\_  
 Physician's Phone: \_\_\_\_\_

Date: \_\_\_\_\_  
 Date: \_\_\_\_\_