

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.