



Resident Camp Health History Form

PLEASE PRINT CLEARLY IN INK.

GIRL MEMBER ADULT MEMBER

CONTACT INFORMATION	Troop #: _____ or Individual <input type="checkbox"/>		Service Unit: _____							
	First Name: _____		Middle Name: _____			Last Name: _____				
	Mailing Address: _____				Apt. #: _____		PO Box: _____			
	City: _____		State: _____		Zip: _____		Phone: () _____			
	Cell: () _____		E-mail: _____							
	Parent/Guardian(s) Name and address <i>(If different from girl's): (Complete for girl form only)</i>						Phone: () _____			
1. _____						Cell: () _____				
Parent/Guardian(s) Name and address <i>(If different from girl's): (Complete for girl form only)</i>						Phone: () _____				
2. _____						Cell: () _____				
Custodial Care Information: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Other: _____										
HEALTH INFORMATION	Name of Family Physician: _____						Phone: () _____			
	Family Medical/Hospital Insurance Carrier: _____						Policy or Group No: _____			
	Family Dental Insurance Carrier: _____						Policy or Group No: _____			
	Health Information: Age: _____ Date of birth: / / <div style="text-align: center;">MM DD YY</div>									
Immunization Record:										
Which of the following have you had?				Please give all dates of immunization:						
<input type="checkbox"/> Measles	Vaccine:			Dates:	Mo/Yr.	Mo/Yr.	Mo/Yr.	Mo/Yr.	Mo/Yr.	Mo/Yr.
<input type="checkbox"/> Chicken Pox	DTP				_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German Measles	TD (Tetanus/Diphtheria)				_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Tetanus				_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	Polio				_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	MMR				_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	Or Measles				_____	_____	_____	_____	_____	_____
	Or Mumps				_____	_____	_____	_____	_____	_____
	Or Rubella				_____	_____	_____	_____	_____	_____
	Haemophilus Influenza B				_____	_____	_____	_____	_____	_____
	Hepatitis B				_____	_____	_____	_____	_____	_____
	Varicella (chicken pox)				_____	_____	_____	_____	_____	_____
Date of last health examination: / /				Were there any medical problems at the time?						
MM DD YY										
Does participant have any physical, mental or psychological conditions requiring medication, treatment, or other special restrictions or considerations?										
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state restriction/consideration and reason: _____										

Does participant take any prescribed medications or over the counter drugs on a regular basis?

Yes No

Fill in the table for any prescription or over the counter medications your camper will be bringing to camp

*****All prescriptions MUST be in their original container*****

Medication and Dose:	Reason for Medication:	Times and Days to be given As needed or prescribed times*	Please note if this is a prescription or over the counter medication

***Please note: we can only administer prescription medication according to directions on the label, unless we have a signed doctor's note.**

OVER THE COUNTER MEDICATIONS

Check all items that we may give your camper, if she should need medication while at camp. All medications are given based on your individual child's weight or age as listed in the instructions.

- Acetaminophen (such as Tylenol or other non-aspirin pain relieve
- Ibuprofen (Motrin, Advil)
- Throat Lozenges
- Antihistamine (such as Benadryl)
- Calamine, Caladryl or other anti-itch lotion
- Antibiotic Ointment (such as polysporin or Neosporin)
- Hydrocortisone cream
- Antacid (Tums)
- Antifungal Ointment or Spray (for athlete's foot)
- Sunscreen (spf 30 max)
- Bugspray (10% Deet max)

Comments: _____

Is participant restricted or limited from participating in any physical activity?

Yes No If yes, please explain: _____

Please provide a record of past medical treatment, if any, including injures or surgeries:

Participant has the following health conditions/allergies/dietary restrictions (food and medications):

- ADHD Asthma Diabetes Headaches Seizures Other: _____
- Allergies (specify): _____

Emergency Contact (non-parent):

Relationship:	Phone: ()	C ell: ()
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AUTHORIZATION

PARENT/GUARDIAN AUTHORIZATION

This health form is complete and accurate. I know of no reason(s), other than the information indicted on this form, why my daughter/girl should not participate in the prescribed activities, including field tris, except as noted. In the event that my daughter/girl needs medical attention while participating in Girl Scout activities, I authorize the adult in charge to see that my daughter/girl receives routine healthcare, medications, reasonable first aid and to transport my child to a health care facility for emergency services as needed. I give permission to take photographs and/or video of my camper for publicity purposes.

Signature of parent/guardian: _____ Date: _____

ADULT MEMBER AUTHORIZATION

This health history is complete and accurate. I am able to engage in all prescribed activities except as noted. I give permission for photographs and/or video to be taken of me for publicity purposes.

Signature of adult member: _____ Date: _____

