



CAMP HEALTH HISTORY AND EXAM EMERGENCY CONTACT INFORMATION

The information on this form is gathered to assist us in identifying appropriate care. It is not part of the acceptance process.

Office Use Only	
Session	_____
Unit	_____
Date	_____
Check In:	
Temp	_____
H.C.	_____
Meds:	yes no

Please return this completed form to the address below with balance due and/or 3 weeks before coming to camp.

Program Registrar
Girl Scouts of Ohio's Heartland Council
1700 WaterMark Dr.
Columbus, OH 43215-1097
www.gsosohioheartland.org

Instructions:

1. Complete pages 1, 3, and 4 of this form.
2. Have your daughter's health care provider complete and sign the statement on page 2.
3. Return entire original signed form to the address at left.
4. All campers must have a signed doctor's statement on file in order to attend camp.

Office Use Only
Camper Name _____
First _____
Middle _____
Last _____
Unit _____
Session Code _____

Camper Name: _____ Birthdate: _____ Age: _____
Last First Middle

Home Address: _____ Grade completed: _____
Street Address City State ZIP

Race/Ethnic (Girl Scouts only): American Indian or Alaska Native Black Also of Spanish/Hispanic Origin
 Asia or Pacific Islander White Other

Custodial Parent/Guardian (or Spouse) : _____ Relationship to Camper: _____ Preferred Phones: () _____
 () _____

EMERGENCY CONTACT (If custodial parent/guardian is not available):

Name: _____ Relationship to Camper: _____ Preferred Phones: () _____
 () _____

Alternate Contact:

Name: _____ Relationship to Camper: _____ Preferred Phone: () _____

Allergies: No known allergies This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet.
 This camper has special food needs. **(Please describe below.)**

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.
(Please describe below.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Insurance Company _____ Policy Number _____
 Subscriber Name _____ Insurance Company Phone Number () _____
 Name of family physician _____ Phone number () _____
 Name of family dentist/orthodontist _____ Phone number () _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Camper Name: _____ Birthdate: _____
First Middle Last

Immunization History: Provide the month and year of the last immunization for each.

Immunization	Month/Year	Immunization	Month/Year
DPT: Diphtheria, Tetanus, Pertussis		PCV: Pneumococcal	
Tetanus booster (required)		Hepatitis B	
MMR: Mumps, measles, rubella		Hepatitis A	
IVP: Polio		Varicella <input type="checkbox"/> Had chicken pox (chicken pox) Date:	
HIB: H. influenza, type B		MCV4: Meningococcal meningitis	

Date of last Tuberculosis (TB) test: _____ Results: Negative Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.
 Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

MEDICATION: This camper will not take any daily medications while attending camp.
 This camper will take the following daily medication(s) while at camp:

“Medication” is any substance a person takes to maintain and/or improve health. This includes vitamins & natural remedies. **Please refer to the Parent Handbook about required packaging/containers. The State of Ohio requires an original pharmacy container with labels, which show the camper’s name and how the medication should be given.** Provide enough of each medication to last the entire time the camper will be at camp.

Name of medication	Type of medication	Reason for taking it	When it is given	Amount or dose given	How it is given
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-prescription		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-prescription		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		
	<input type="checkbox"/> Prescription <input type="checkbox"/> Non-prescription		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other:		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those medications that the camper should not be given.**

- | | |
|---|--|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Phenylephrine decongestant (Sudafed PE) | Pseudoephedrine decongestant (Sudafed) |
| Antihistamine/allergy medicine | Guaifenesin cough syrup (Robitussin) |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM) |
| Salt water gargle for sore throat | Generic cough drops |
| Calamine lotion (Caladryl) | First Aid Cream |
| Laxatives for constipation (Ex-Lax) | Aloe for minor burns, sunburn |
| Solarcaine for sunburn | Bismuth subsalicylate for diarrhea, upset stomach (Pepto-Bismol) |
| Pepcid AC for heartburn, acid indigestion | |

I authorize the camp personnel to administer the above medication to my camper while in attendance at camp.

Signature of Custodial Parent/Guardian: _____ Date: _____

Camper Name: _____

Birthdate: _____

General Health History: Check “Yes” or “No” for each statement. Explain “Yes” answers below.

Has/does the camper:

- | | |
|---|---|
| 1. Ever been hospitalized?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have problems with falling asleep/sleepwalking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Have an orthodontic appliance being brought to camp?.. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Ever had head lice?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have frequent headaches?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Ever had a head injury?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Ever had frequent ear infections?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Wear glasses, contacts, or protective eye wear?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Had chicken pox?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Had fainting or dizziness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Had measles?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Passed out/had chest pain during exercise?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. Had mumps?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Had mononucleosis (‘mono’) in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Had hepatitis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain “Yes” answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check “Yes” or “No” for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? Yes No
2. Ever been treated for emotional difficulties or an eating disorder?..... Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
4. Had a significant life event that continues to affect the camper’s life? Yes No

Please explain any “Yes” answers in the space below, noting the number of the questions. The camp may contact you for additional information.

What have we forgotten to ask? Please provide in the space below any additional information about the camper’s health that you think is important or that may affect the camper’s ability to fully participate in the camp program. Attach additional information if needed.