2017 Summer Camp Health History *(and Exam Form for resident camp)*

BRING TO CAMP OPENING DAY

DO NOT MAIL

KEEP A COPY FOR YOUR RECORDS. THE COUNCIL WILL NOT KEEP ONE ON FILE.

Camp/Program(s)_____ **Date(s)**_____

Name _____ Gender _____ Age _____ Birth Date ____/____/____

Address _____ City _____ State _____ Zip _____

Parent Home Phone (_____)_____ Parent Cell Phone (_____)_____

PARENT CONTACT INFORMATION

We will call in an emergency or if we have questions about your child. Provide contact information for two alternates who know your child should we be unable to reach you.

Parent/Guardian Contact	Daytime/Cell Phone	Evening Phone
Alternate Contact	Phone	Relationship to Camper
Alternate Contact	Phone	Relationship to Camper

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE

The following health history is current and the person described has permission to participate in all camp activities, except as noted by me and/or the examining medical personnel. I give my permission for the adult in charge to give routine health care, transport her to the next level of medical care if needed, obtain emergency medical treatment, and administer medications. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian _____ Date _____

Important - This Box Must be Completed for Attendance

BILLING INFORMATION for HEALTH CARE

There is no charge for health care received from the provider at camp. However, parents/guardians are financially responsible for health care given by an out-of-camp provider. The Girl Scout council provides sickness and accident insurance to serve as secondary insurance coverage; it is not intended to replace the benefits that may be available under a family plan. Whom should we route charges for this camper's health care? Include a copy of both sides of an insurance card. Note: It is your responsibility to check on the portability of your policy.

Name of Insured: _____ Relationship to camper: _____

Carrier:_____ Policy or Group # _____

_____ (_____)_____

Insurance Claims Mailing Address Insurance Claims Telephone

Policy Owner's Social Security Number: _____

☐ My child has no medical insurance. I will assume responsibility for any medical charges incurred while at camp.

HEALTH HISTORY to be filled out by <u>parent/guardian</u> within six months prior to the camper's participation in camp. Note changes, which occur and inform the camp health care director via written notification.

Immunization History: provide the month and year for each immunization. Immunizations must be current.
Tetanus booster: _____ DTAP: _____ MMR: _____ Polio:_____

I attest that all my child's immunizations required for school are up to date (sign and date) _____

Allergies list allergy, describe reaction and management of reaction
Medication allergies: _____
Food allergies: _____
Other allergies: (include hay fever, asthma, animal dander, poison ivy, insect stings or history of insect allergies in family): _____
_____
Dietary Restrictions: _____
_____

Chronic Concerns Check all that pertain to this camper and provide information about supportive health care.
☐ This camper has no chronic health concerns and is capable of full participation in this program.
☐ This camper has the following chronic health concern(s):

☐ Asthma	☐ Headaches	☐ Frequent nosebleeds	☐ Bed-wetting	☐ Diarrhea/constipation
☐ Diabetes	☐ Frequent ear infections	☐ Frequent colds & sore throats	☐ Sleepwalking	☐ Fainting
☐ Epilepsy	☐ Menstrual cramps	☐ Heart defect/disease	☐ Back/joint pain	☐ Other (explain below)

Provide information about supportive health care needed for each checked item:
_____
_____

Recent History: Circle the response appropriate to each statement.
YES NO This camper has had chicken pox.
YES NO This camper has had mononucleosis in the past twelve months.
YES NO This camper has been hospitalized in the past twelve months.
YES NO This camper has had an infectious disease in the past twelve months.
YES NO This camper has a history of illness, injury, or surgery, which will affect participation. If "yes," explain:
_____
_____

Emotional Health: Has the camper:
YES NO Even been treated for attention deficit disorder (ADD) or attention deficit/hyperacticity disorder (AD/HD)?
YES NO Even been treated for emotional or behavioral difficulties or eating disorders?
YES NO During the past 12 months, seen a professional to address mental/emotional health concerns?
Please provide background information to help us work effectively with your camper:
_____
_____

Restrictions:
☐ I have reviewed the program and activities of the camp and feel my camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel my camper can participate with the following restrictions or adaptations:
_____
_____

Name of camper's dentist/orthodontist_____ Phone (_____)_____

Name of camper's physician _____ Phone (_____)_____

CampTogowoods only keeps the following medications in stock for use in treating campers with illnesses/injuries occurring at camp: ***Tylenol, Motrin, Benadryl, Robitussin, Triaminic, Bacitracin, Immodium, Maalox, Nix, Hydrocortisone and Caladryl.*** These medications may be dispensed to your child as deemed necessary in accordance with physician-approved treatment procedures. If you object to the use of any or all of the above medications, please state so below:
_____
_____

MEDICATIONS Provide complete information. Bring enough medication to last the entire session. Prescription and non-prescription medications MUST be in pharmacy or original containers and appropriately labeled. (see Parent/Camper Handbook)
☐ This camper does not take any medication on a regular basis.
☐ This camper takes the following medication during the school year, but will not continue it at camp: _____
☐ This camper takes routine medication (include non-prescription, vitamins and ointments/cremes) as follows:
(attach more information if needed):

Name of Medication	Reason for Taking	Dose Taken	How often each day?

RESIDENT CAMP PROGRAMS ONLY

MEDICAL EXAM – it is recommended, not required, that this form be completed by a licensed physician or nurse practitioner or other healthcare provider liscensed by the state and can be based on an examination done within the past 6 months.

Name: _____ **Birthdate:** _____

Date of Physical Examination: _____

Heart Rate: _____ Height: _____ Weight: _____

Blood Pressure: _____ Temperature: _____

This person is under the care of a physician for the following:

_____

_____

_____

Any treatment to be continued at camp: _____

_____

_____

_____

Current treatment (include current medications): _____

_____

_____

Medications, which this person will bring and take while at camp (provide medical order for administration): _____

_____

_____

_____

Any allergies (food, drugs, plants, insects, etc.): Include treatment for allergic response. _____

_____

_____

_____

Recommendations and restrictions of any activities while at camp: _____

_____

_____

Additional Health Information: _____

_____

_____

_____ (____) _____

Signature Telephone

_____

Street Address City State Zip

Date of form completion: _____ * By: _____

Initial if completed by nurse or physician's assistant.

CAMP HEALTH NOTES for camp use only

SCREENING has been conducted within 24 hours of arrival and significant findings noted

1. Signs/symptoms of illness or injury upon arrival? (resident camp) ..... NO YES as noted below
2. History of recent exposure to communicable disease? (resident camp)..... .... NO YES as noted below
3. Additions or corrections to information on health history (resident camp)..... ... NO YES as noted below
4. Any signs/symptoms of head lice? (resident camp)..... ... NO YES as noted below
5. Medication given to health care director?..... .....NO YES as noted below
6. Review completed?..... NO YES as noted below

Date/Time **Initial**

_____

_____

_____

_____

NURSING NOTES

Date/Time **Nursing Notes** **Initial**

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EXIT NOTE (check one of the following):

- ☐ Left camp this day with no reported illness or injury symptoms.
- ☐ Left camp this day with the following problem/concern:

_____

This problem was referred to (name of person): _____

Date: _____ **Initial:** _____