Girl Scouts
Minnesota and Wisconsin River Valleys

2009 Camp Health History Form
for Troop, Adult and Me, and Family Weekend Programs
(Needed for all girls and adults attending – please bring to camp with you)

Program Name________________________________ Dates Attending___________________________

Name of participant__________________________________ Sex________ Age________ Birth Date ____/____/____

Address_________________________________ City____________________________ State______ Zip_____________

Home Phone (______)________________________________ E-mail Address_____________________________________

PARENT CONTACT INFORMATION
We will call in an emergency or if we have questions about your child.

Parent/Guardian Contact___________________________________ Daytime Phone (_____)________________ Evening Phone (_____)__________________

Address_______________________________________ City____________________________ State______ Zip______________

Relationship to participant________________________ Other Contact Phone (cell phone, etc.) (_____)_____________________

Alternate_____________________________________ Phone (_____)_________________ Relationship____________________

Alternate_____________________________________ Phone (_____)_________________ Relationship____________________

HEALTH INSURANCE
Parents/guardians are financially responsible for health care given by a healthcare provider. Girl Scouts 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. If you are not sure about any of the below items, please include a copy of the insurance card.

Name of person insuring participant________________________________ Relationship to participant_______________________

SSN of above person____ Birth date of above person________/________/________

Full name of insurance company____

Identification #____ Policy or Group #__________________________________

Address for claims____ Phone: (______)___________________

To the best of my knowledge the Health History is complete and accurate. My girl has permission to engage in all program activities except as noted by the physician and/or myself. In the event I cannot be reached in an emergency, I give permission for camp authorities to take necessary emergency action, which may include related transportation, admission to a hospital, X-rays, routine tests, emergency surgery, and treatment for the health of my child. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is also my intention that a camp authority be treated as a "personal representative" for purposes of disclosing protected health information to keep me informed of my child's health status. Girl Scouts provides sickness and accident insurance to serve as secondary insurance coverage. This insurance is not intended to replace the benefits that may be available under a family insurance plan. This completed form may be photocopied for trips out of camp. This information will be shared with camp staff as appropriate. If for religious reasons you cannot sign this, please contact us for a legal waiver which must be signed for attendance.

Custodial Parent/Guardian Signature: Date:

Camp Health History Form (con't)

Medication allergies _______________________________________ Reaction and Treatment ____

Food allergies _______________________________________ Reaction and Treatment ____

Other allergies
(hayfever, animals, plants, insect stings, asthma) _______________________________________ Reaction and Treatment ____

Chronic Concerns: Check all that pertain to this participant and provide information about supportive health care.

- ☐ This participant has no chronic health concerns and is capable of full participation in this program.
- ☐ This participant has the following chronic health concern(s):
  - ☐ Asthma
  - ☐ Headaches
  - ☐ Sleep walking
  - ☐ Bed wetting
  - ☐ Diabetes
  - ☐ Frequent ear infections
  - ☐ Frequent colds & sore throats
  - ☐ Epilepsy/Seizures
  - ☐ Menstrual cramps
  - ☐ Other (please describe) ___________________________________

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

General Information
Has the participant had any recent illness or infectious disease, including chicken pox or mononucleosis in the past 12 months?
If "yes," explain:
____

Has the participant had a history of illness, injury or surgery which will effect participation? If "yes," explain:
____

Has the participant had any behavior and/or emotional problems? If "yes," explain: ____
____

Has the participant ever required any psychiatric counseling or hospitalization? If "yes," explain: ______________________________
____

Name of participant's dentist/orthodontist______________________________________ Phone (______)______________________

Name of participant's physician____ Phone (______)______________________

Immunizations

Initial here if the participant is current on all immunizations___________

Date of last tetanus booster (TD)___________

Date of last MMR___________

Date of last Tuberculin Test____________

Date of last Hepatitus B_______________

Medication (including vitamins and over the counter medications)

Name of Medication____________________________

Dose____

Reason for Taking______________________________

Name of Medication____________________________________

Dose____

Reason for Taking______________________________________