

2008 Health History—Olympic Dreams

This form must be received 4 weeks before your camper's session date.

Mail this form to the following address: Cindy Marcotte GS Daycamp, 2159 Douglynn Lane, St. Paul, MN 55119

Emergency Contact Information

Camper's Name _____ Birth date _____ Age at Camp _____
Last First Middle Initial

Home address: _____
Street Address City State Zip Code

Camper is in the custodial care of (check one) Both parents Mother Only Father Only Other:

Custodial Parent/Guardian Name: _____ Daytime Phone: _____

In Emergency please contact me at: (Please choice one) Cell Phone Pager Home Work Emergency Phone: _____

Home Address(if different from above): _____

Second Parent/Guardian Name: _____ Daytime Phone: _____

In Emergency please contact me at: (Please choice one) Cell Phone Pager Home Work Emergency Phone: _____

Home Address(if different from above): _____

FIRST ALTERNATE EMERGENCY CONTACT (Not parent/Guardian - This name must be listed)	SECOND ALTERNATE EMERGENCY CONTACT
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State Zip _____	City, State Zip _____
Emergency Phone: _____	Emergency Phone: _____
Other than Custodial Parents, camper may be released to (please list): _____	Are there individuals that the camper can not be released to? (please list): _____

Family Medical/Hospital insurance carrier – Is the camper covered by family medical/hospital insurance? Yes No

If yes, indicate carrier or plan name: _____ Group /ID# _____

☞ Photocopy of the front and back of Health Insurance card must be sent with this form.

Family Physician Name: _____ Phone: _____

Clinic Name and Address: _____

Family Dentist/Orthodontist Name: _____ Phone: _____

Clinic Name and Address: _____

To the best of my knowledge the Health History & Physical Exam are complete and accurate. My daughter has permission to engage in all prescribed 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. The Girl Scout Council 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 counseling staff as appropriate.

NAME:
Unit:

Custodial Parent/Guardian Signature: _____ Date: _____

The following information must be filled in by the Custodial Parent/Guardian. The intent of this information is to provide camp health care staff the background to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided to camp healthcare staff upon camper's arrival at camp. Please provide complete and accurate information so that camp staff can be aware of your camper's needs.

ALLERGIES - List all known. Describe reaction and how to manage a reaction.

Medication or Food Allergies (list)	Reaction and Management of reaction

MEDICATIONS BEING TAKEN - List all medications (including over-the-counter or nonprescription drugs) take routinely.

Keep prescription medication in its original pharmacy container that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. All Medications will be administered by an adult.

This camper takes NO medications on a routine basis.

This camper takes these medications as follows:

Medication #1: _____	Dosage: _____	Specific times taken each day: _____
Reason for taking: _____		
Medication #2: _____	Dosage: _____	Specific times taken each day: _____
Reason for taking: _____		

RESTRICTIONS – The following restrictions apply to the camper.

Restrictions (activities/diet): Explain any restrictions camper may have while at camp and adaptations or limitations as necessary:

Please check if immunizations are up to date:

Provide any additional information about the camper's behavior and physical, emotional, or mental health about which the camp should be aware (attach a note if necessary).