

2009 Camp Health History Form

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

Mail or fax this form to:

Girl Scouts of Minnesota and Wisconsin River Valleys · 5601 Brooklyn Boulevard · Brooklyn Center, MN 55429 · Fax 763-535-7524

Emergency Contact Information

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

Home Address: _____
Street Address City State Zip Code

Camp attending: (check one) Camp Elk River Camp Greenwood Camp Lakamaga Camp Northwoods
 Camp Sanderson Camp Singing Hills Camp Whispering Hills Rochester Day Camps

CAMP SESSION NAME: _____ SESSION DATE: _____

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

Custodial Parent/Guardian Name: _____ Daytime Phone: _____

In emergency, contact me at: (Please choose one) Cell Phone Pager Home Work Emergency Phone: _____

Home Address (if different from above): _____

Second Parent/Guardian Name: _____ Daytime Phone: _____

In emergency, contact me at: (Please choose one) Cell Phone Pager Home Work Emergency Phone: _____

Home Address (if different from above): _____

FIRST ALTERNATE EMERGENCY CONTACT <small>NOT Parent/Guardian - This name must be listed</small>	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 cannot 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: _____

CAMPER'S NAME:

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: _____

2009 HEALTH HISTORY

Camper's Name:

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 health care 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 Allergies (list):	Reaction and management of reaction:
Food Allergies (list):	Reaction and management of reaction:
Other (list): (e.g. animals, hay fever, insect stings, plant, pollen)	Reaction and management of reaction:

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

Please bring enough medication to last the entire camp session. 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.

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:		
Medication #3:	Dosage:	Specific times taken each day:
Reason for taking:		

Attach additional pages for more medications. Identify any medications that the camper may take during the school year that they will not be taking during camp. (list here):

RESTRICTIONS – The following restrictions apply to the camper.

Dietary

- Does not eat red meat
 Does not eat pork
 Does not eat eggs
 Does not eat poultry
 Does not eat seafood
 Does not eat dairy products
 Other – Specify: _____

Activity Restrictions

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary):

2009 HEALTH HISTORY, continued

Camper's Name: _____

GENERAL HEALTH QUESTIONS – (Explain any “yes” answers below.)

Has/does the participant:	YES	NO	Has/does the participant:	YES	NO
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g. itching, rash, ache)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. Has camper started menstruating?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	30. Does the camper have body piercing and/or body art?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	31. Has the camper traveled outside of the United States in last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any “yes” answers, noting the number of the question(s).

<p>Which of the following has the camper had?</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> German measles</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Hepatitis A</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Hepatitis C</p> <p>TB Mantoux Test</p> <p>Date of last test _____</p> <p>Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative</p>	<p>Please give all dates of immunization: <input type="checkbox"/> PLEASE (✓) HERE IF ALL IMMUNIZATIONS ARE UP TO DATE.</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #e0e0e0;"> <th style="text-align: left;">Vaccine:</th> <th style="text-align: left;">Dates:</th> <th style="text-align: center;">Mo/Yr.</th> <th style="text-align: center;">Mo/Yr.</th> <th style="text-align: center;">Mo/Yr.</th> <th style="text-align: center;">Mo/Yr.</th> <th style="text-align: center;">Mo/Yr.</th> <th style="text-align: center;">Mo/Yr.</th> </tr> </thead> <tbody> <tr> <td>DTP</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>TD (tetanus/diphtheria)</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Tetanus</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Polio</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>MMR</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Or Measles</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Or Mumps</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Or Rubella</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Haemophilus influenza B</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Hepatitis B</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Varicella (chicken pox)</td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>	Vaccine:	Dates:	Mo/Yr.	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Use this space (or an additional sheet) to provide any additional information about the camper's behavior and physical, emotional, or mental health about which the camp staff should be aware.

FOR CAMP USE ONLY

Screening Record

Date screened: _____ Time _____ a.m./p.m.

Meds received: _____

Updates/additions to Health History noted: Yes No None Required

Current health needs identified: _____

Observational notes: _____

Screened by: _____