girl scouts

Girl Scouts of Western Washington

Community Camper Health History & Consent to Treat

Camper's Full Name: _____ Date of Birth: _____

Girl Scout Camp Attending: ☐ Camp Lyle McLeod ☐ Camp St Albans

Community Camp Name:_____ Program Dates: _____

Please attach extra sheets inside if you need more room to write.

Allergies

☐No known allergies

☐This camper is allergic to (*please list allergy and reactions-use additional sheets if necessary*):

☐Food

☐Medications

☐Environment (plants, insects)

☐Other (chemical, latex, etc)

☐ Check here to request follow up for Action Plan development with the Camp Nurse.

Diet and Nutrition

☐This camper eats a regular diet

☐This camper eats a regular vegetarian/vegan diet (please circle which one)

☐This camper has special food needs (*please describe below*)

_____

_____

_____

_____

Mental, Emotional and Social Health: Circle "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 or behavioral difficulties or an eating disorder? **Yes** **No**
3. During the past 12 months, see a professional to address mental/emotional health concerns? **Yes** **No**
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, other) **Yes** **No**

Please Explain:

_____

_____

_____

_____

Camper Name: Last MI First Unit: Community camp::

General Health History

If <u>any</u> of the following statements apply to the camper, please circle the number to indicate "Yes."

Has/Does the camper:

1. Ever been hospitalized?	11. Had fainting or dizziness?
2. Ever had surgery?	12. Passed out/had chest pain during exercise?
3. Have recurrent/chronic illnesses?	13. Had mononucleosis ("mono") in the past 12 months?
4. Had a recent infectious disease?	14. Started menstruation? Any problems?
5. Had a recent injury?	15. Have problems with falling asleep or sleep walking?
6. Ever had back/joint problems?	16. Had asthma/wheezing/shortness of breath?
7. Have diabetes?	17. Have a history of bedwetting?
8. Had seizures?	18. Have problems with diarrhea/constipation?
9. Had headaches?	19. Wears glasses, contacts or protective eyewear?
10. Have any skin problems?	20. Traveled outside the country in the past 9 months?

Please explain any "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name the countries visited and dates of travel. Use additional sheets if necessary.

_____

_____

_____

_____

Note: Campers that have any serious illness, injury or surgery in the last 18 months need a physical exam. The Physician's Health Exam *form can be found on our website www.girlscoutsww.org.*

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 on a separate sheet).*

Anything else? ***Please provide on a separate sheet*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program.

Immunizations

Give the dates (year) of the last immunization or booster, or attach a copy of official immunization record.

_____ Tetanus _____Chicken Pox _____Measles/Rubella _____Mumps

_____ Flu _____Diphtheria/Pertussis (DTaP/DT) _____Hepatitis A

_____Hepatitis B

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:**_____

Health Care Providers

Name of Camper's Physician_____ Phone ( )_____

Name of Camper's Dentist_____ Phone ( )_____

Medical Insurance Information:

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

Include a copy of your insurance card if appropriate; copy both sides so the information is able to be read.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number_____

Medications

☐This camper will not take any daily medications while attending camp

☐This camper will take the following medications while at camp (Please list below. Attach an additional sheet as needed). Please include dosage and times.

Please remember to send medications with a provided Medication Form, in the original containers, with physician prescription details. Medications in other containers, such as daily pill reminders, will not be accepted.

_____

_____

_____

_____

Non-Routine Medications

Occasionally, campers contract minor medical conditions that can be treated by non-prescription medications. These are stocked in the camp Health Center and are used on an as needed basis under the Health Procedures signed by our Health Care Provider. Medications may be generic or the store brand equivalent. Medications that come in tablet form can also be administered in liquid form. **Cross out / strike through those the camper should not be given:**

For Pain: Acetaminophen, Ibuprofen

For Cough/Cold: Pseudoephedrine, Phenol Spray or menthol lozenges, Guaifenesin and Dextromethorphan HBr

Insect bites or Poison Ivy & Oak with swelling: Diphenhydramine tablets or cream, Calamine/Caladryl lotion, Hydrocortisone Cream ≤ 1%

Digestive Upsets: Bismuth subsalicylate, Calcium Carbonate, Docusate Calcium, Magnesium Hydroxide, Loperamide HCl, Peppermints

Cuts, Scrapes, Splinters: Bacitracin / Neomycin / Polymyxin ointment

Athlete's Foot: Clotrimazole Cream

Note: Campers displaying symptoms of head lice will need to be treated at home and can return to camp when they are nit-free (usually 24 hours)

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 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 adult volunteer about my child's health status.

Signature of Custodial Parent/Guardian:_____ **Date:**_____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Emergency/Alternate Contact

Child's Name_____
Last MI First

Address_____
Street Apt City State Zip

1 Parent Name (custodial parent or guardian)_____

Home ( )_____ Work ( )_____ Cell ( )_____

2 Parent Name_____

Home ( )_____ Work ( )_____ Cell ( )_____

Where can you be reached ***during camp***? _____
If you plan to be out of town, please attach your itinerary and contact numbers.

In case we cannot reach you, list at least two relatives or friends who you can authorize to act on your behalf, including health care decisions, **and** to whom your child can be released during the session for whatever reason:

Name_____ Phone ( ) _____

Name_____ Phone ( ) _____

Individual Record of Health Care and Treatment at Camp

Camp Use Only Please. Parents/Guardians: Please do not write in this section

Date	Time	Complaint/Condition	Assessment	Treatment	Health Supervisor. Signature