

Resident Camp Health Form

Health Information and Health Exam Sections



Girl Scouts of NE Kansas & NW Missouri
 8383 Blue Parkway, KC, MO 64133
 (816) 358-8750 Fax (816) 358-5714
www.girlscoutsksmo.org

The information on this form is gathered to assist us in identifying appropriate care for your camper during her camp stay. Keep a copy of the completed form for your records. Any changes to this form should be provided upon participant's arrival at camp. Please provide complete information so that the camp health personnel can be aware of your camper's needs.

The Health Information Section (first 3 pages) must be completed by camper's parent or guardian within 2 months of camp attendance. The Health Examination Section (last page) must be completed by a doctor, physician's assistant or nurse practitioner within 24 months of camp attendance.

Health Information Section

Name _____		SSN _____	
Birthdate _____		Gender M F	Age at camp _____
Home Address _____			
Street	City	State	Zip

1. Parent/Guardian name _____
 Relationship to camper _____
 Day phone (____) _____ Evening phone (____) _____
 Cell phone (____) _____ Pager/other (____) _____

2. Parent/Guardian name _____
 Relationship to camper _____
 Day phone (____) _____ Evening phone (____) _____
 Cell phone (____) _____ Pager/other (____) _____

Camper lives with (mark all that apply) ___ mother ___ father ___ step-mother ___ step-father ___ grandparent(s) ___ other _____

If parents/guardians are not available in an emergency, please notify

Name _____
 Relationship to camper _____
 Day phone (____) _____ Evening phone (____) _____
 Cell phone (____) _____ Pager/other (____) _____

Name _____
 Relationship to camper _____
 Day phone (____) _____ Evening phone (____) _____
 Cell phone (____) _____ Pager/other (____) _____

Is the camper covered by family medical/hospital insurance? Yes No
 If so, indicate carrier or plan name _____ Group number _____
 If camper is insured, a **photocopy of front and back of health insurance cards must be attached to this form.**

(Girl Scout insurance will cover usual and reasonable charges for sickness and accident treatment during camp but does not eliminate the need for individual insurance. The Girl Scout Council is not responsible for providing full insurance coverage. It is necessary for you to provide secondary insurance. Please contact your provider to check on your coverage.)

Name _____
 Last _____
 First _____
 MI _____
 Session # _____
 Program _____

For office use only.

Allergies

List all known allergies to medication, food, plants, animals, etc. Describe reaction and management of the reaction.

Medications Being Taken

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire camp session. Medications must be in their original bottle/container that identifies the prescribing physician (if prescription), the name of the medication, the dosage, and the frequency of administration.

_____ This camper takes NO medications on a routine basis.

_____ This camper takes routine medications as follows:

Medication _____ Dosage _____ Time of day _____

Reason for taking _____

Medication _____ Dosage _____ Time of day _____

Reason for taking _____

Medication _____ Dosage _____ Time of day _____

Reason for taking _____

(Attach additional pages for more medications.)

Please identify any medications taken during the school year that participant does/may not take during the summer.

Restrictions

Please list any dietary restrictions for this camper.

Please list and explain any restrictions to activity, such as strenuous activity, swimming, diving, etc.

General Questions – please circle your response

All “yes” answers should be explained in the space provided below.

Has/does the camper:

- | | |
|--|--|
| 1. Had any recent injury, illness or infectious disease?
Yes No | 15. Ever been diagnosed with a heart murmur? Yes No |
| 2. Have a chronic or recurring illness/condition? Yes No | 16. Ever had back problems? Yes No |
| 3. Ever been hospitalized? Yes No | 17. Ever had problems with joints (e.g., knees, ankles)? Yes No |
| 4. Ever had surgery? Yes No | 18. Ever had a heat related illness or problem? Yes No |
| 5. Have frequent headaches? Yes No | 19. Have any skin problems (e.g., itching, rash, acne)? Yes No |
| 6. Ever had a head injury? Yes No | 20. Have diabetes? Yes No |
| 7. Ever been knocked unconscious? Yes No | 21. Have asthma? Yes No |
| 8. Wear glasses, contacts or protective eye wear? Yes No | 22. Had mononucleosis in the past 12 months? Yes No |
| 9. Ever had frequent ear infections? Yes No | 23. Had problems with diarrhea/constipation? Yes No |
| 10. Ever passed out during or after exercise? Yes No | 24. Had problems with sleepwalking? Yes No |
| 11. Ever been dizzy during or after exercise? Yes No | 25. Have an abnormal menstrual history? Yes No |
| 12. Ever had chest pain during or after exercise? Yes No | 26. Have a history of bed-wetting? Yes No |
| 13. Ever had seizures? Yes No | 27. Ever had an eating disorder? Yes No |
| 14. Ever had high blood pressure? Yes No | 28. Ever had emotional difficulties for which professional help was sought? Yes No |

Please explain any “yes” answers including the date of occurrence, noting the number of the questions. **For diabetes or asthma**, attach a sheet explaining treatment in detail. For asthma, include frequency of attacks, triggers, action plan, peak flows, etc.

Name
Last

First

MI

Session #

Program

Menstruation

Has this camper menstruated? Yes No If not, has she been told about it? Yes No
 If your daughter will be menstruating while she is at camp, she must use tampons if she wishes to swim. Some families prefer to have their camper sit out of swimming activities.
 ___ My daughter is permitted to wear tampons. ___ My daughter should abstain from swimming while menstruating.

Health History

Which of the following has the camper had?	Please give all dates of immunization for:							
___ Measles	Vaccine	Dates	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
___ Chicken pox	DTP		___	___	___	___	___	___
___ German Measles	TD		___	___	___	___	___	___
___ Mumps	Tetanus		___	___	___	___	___	___
___ Hepatitis A	Polio		___	___	___	___	___	___
___ Hepatitis B	MMR		___	___	___	___	___	___
___ Hepatitis C	or Measles		___	___	___	___	___	___
	or Mumps		___	___	___	___	___	___
	or Rubella		___	___	___	___	___	___
TB Mantoux Test	H. Influenza B		___	___	___	___	___	___
Date of last test _____	Hepatitis B		___	___	___	___	___	___
Result <input type="checkbox"/> positive <input type="checkbox"/> negative	Varicella/Chicken pox		___	___	___	___	___	___

Use this space to provide any additional information about the camper's behavior and physical, emotional or mental health which may be of assistance in providing care for this camper.

Name of family physician _____ Phone (____) _____

Address _____

Name of family dentist/orthodontist _____ Phone (____) _____

Address _____

The person herein named has permission to engage in all camp activities, including trips out of camp related to camp program, except as noted. I have read the camp brochure and parent handbook and understand and agree to comply with all procedures.

This health history is correct and complete as far as I know. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications and emergency treatment for my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510 (b)) to the disclosure to camp representatives of the protected health information of the person herein described as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

I authorize any hospital, physician, medical practitioner, clinic, or other related facility to furnish to Mutual of Omaha Insurance Company, or anyone acting on its behalf, all information concerning medical, dental and hospital records for my child, to be used for the purpose of evaluating claims for benefits. I have the right to receive a copy of this authorization upon request.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization and/or injection and/or anesthesia and/or surgery for the person named above. This completed form may be photocopied for trips out of camp.

Photographs taken of my daughter may be used by Girl Scouts of NE KS & NW MO, Inc., its assigns or successors, in whatever way they may desire including television and the World Wide Web. Furthermore, I consent that such photographs and plates from which they are made shall be their property and they have the right to sell, duplicate, reproduce, in the form of advertising or otherwise publish, and make other uses of such photographs and plates as they may desire, free and clear of any claim whatsoever on my part.

Signature of parent or guardian _____

Printed name _____ Date _____

Witness _____ Date _____

Name _____
 Last _____
 First _____
 MI _____
 Session # _____
 Program _____

Camper's Name _____ SSN _____

Name
Last
First
MI
Session #
Program

Health Exam Section

The Health Exam Section must be completed by a doctor, physician's assistant or nurse practitioner within 24 months of camp attendance.

I examined this person on _____ (date).

BP _____ Weight _____ Height _____

In my opinion, the above participant _____ is or _____ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp _____

Medications to be administered at camp (name, dosage, frequency) _____

Any medically-prescribed meal plan or dietary restrictions _____

Known allergies _____

Description of any limitation or restriction on camp activities _____

Additional information or comments for health care staff at the camp _____

Signature of Licensed Medical Personnel _____	
Printed Name _____	Title _____
Address _____	
Phone (_____) _____	Date _____