



Girl Scouts of Greater Atlanta, Inc.

Camper Health History Form

This form is to be used by campers attending a summer camp sponsored by Girl Scouts of Greater Atlanta. The health history must be submitted to the Service Center in Mableton by May 1.

CAMP NAME _____

SESSION DATES _____ **YEAR** _____

Camp Use Only - Arrival Day Screening

Unit Assignment _____

Is your contact information up to date?
 Do you have prescription medication to check in?
 Does your camper have any meds in her luggage?
 Does your camper have an asthma inhaler?
 - Does she need her inhaler in her backpack?
 Any dietary restrictions? Any mobility restrictions?
 Will you be travelling during the camp session?
 Is the camper immunization record attached?
 Did you circle OTC meds we may administer?
 Is the health exam signed & within 24 months?
 Ask additional screening questions.

FULL NAME	DATE OF BIRTH	AGE
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HOME ADDRESS _____

CITY, STATE AND ZIP CODE _____

PARENT/GUARDIAN FULL NAME	HOME PHONE
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HOME ADDRESS	CELL PHONE
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CITY, STATE AND ZIP CODE	BUSINESS PHONE OR SECOND CELL
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IN EMERGENCY NOTIFY

NAME & RELATIONSHIP	AREA CODE + PHONE
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NAME & RELATIONSHIP	AREA CODE + PHONE
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FAMILY PHYSICIAN	AREA CODE + PHONE
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INSURANCE COMPANY NAME	AREA CODE + PHONE
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NAME OF POLICY HOLDER	POLICY/GROUP NUMBER
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PARENT LOCATION DURING CAMPER STAY: HOME OUT OF TOWN - Please bring details to check in day

PARENT/GUARDIAN AUTHORIZATION

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why this camper, should not participate in prescribed activities except as noted. I understand that this information will remain confidential to appropriate camp personnel, the designated person trained in first aid, or emergency personnel as needed. I authorize the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I authorize the camp to arrange necessary related transportation for my child.

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, for the person named above. This completed form may be photocopied for trips out

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE THIS FORM WAS SIGNED

Health Information Provided by Parent/Guardian

ALLERGIES List all known.

Medication Allergies (list)

Describe reaction and management of the reaction.

Food Allergies (list)

Describe reaction and management of the reaction.

Other Allergies (list)

Insect stings, hay fever, asthma, animal dander, 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 time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

1. Med _____ Dosage _____

Specific times taken each day _____

Reason for taking _____

2. Med _____ Dosage _____

Specific times taken each day _____

Reason for taking _____

3. Med _____ Dosage _____

Specific times taken each day _____

Reason for taking _____

4. Med _____ Dosage _____

Specific times taken each day _____

Reason for taking _____

Identify any medications taken during the school year that participant does/may not take during the summer:

Health Information Provided by Parent/Guardian

GENERAL QUESTIONS (Explain "yes" answers below.)

- | | YES | NO | | YES | NO |
|--|-----|----|---|-----|----|
| 1. Had any recent injury, illness or infectious disease? | | | 19. Have any skin problems (e.g., itching, rash, acne)? | | |
| 2. Have a chronic or recurring illness/condition? | | | 20. Have diabetes? | | |
| 3. Ever been hospitalized? | | | 21. Have asthma? | | |
| 4. Ever had surgery? | | | 22. Had mononucleosis in the past 12 months? | | |
| 5. Have frequent headaches? | | | 23. Had problems with diarrhea/constipation? | | |
| 6. Ever had a head injury? | | | 24. Have problems with sleepwalking? | | |
| 7. Ever been knocked unconscious? | | | 25. Have an abnormal menstrual history? | | |
| 8. Wear glasses, contacts or protective eye wear? | | | 26. Have a history of bed-wetting? | | |
| 9. Ever had frequent ear infections? | | | 27. Ever had an eating disorder? | | |
| 10. Ever passed out during or after exercise? | | | 28. Ever had emotional difficulties for which professional help was sought? | | |
| 11. Ever been dizzy during or after exercise? | | | 29. Ever had measles? | | |
| 12. Ever had seizures? | | | 30. Ever had chicken pox? | | |
| 13. Ever had chest pain during or after exercise? | | | 31. Ever had german measles? | | |
| 14. Ever had high blood pressure? | | | 32. Ever had mumps? | | |
| 15. Ever been diagnosed with a heart murmur? | | | 33. Ever had hepatitis A? | | |
| 16. Ever had back problems? | | | 34. Ever had hepatitis B? | | |
| 17. Ever had problems with joints (e.g., knees, ankles)? | | | 35. Ever had hepatitis C? | | |
| 18. Have an orthodontic appliance being brought to camp? | | | 36. Ever had tuberculosis? | | |

Please explain any "yes" answers, noting the number of the questions.

SEND MOST CURRENT IMMUNIZATION RECORDS WITH HEALTH EXAM FORM.

SEND ANAPHYLAXIS ACTION PLAN WITH HEALTH EXAM FORM- if necessary. This form is located on the website.

SEND ASTHMA ACTION PLAN WITH HEALTH EXAM FORM- if necessary. This form is located on the website.

OVER THE COUNTER MEDICATIONS

Please check mark the over the counter medications we may administer to your child.

- | | |
|--|--|
| <input type="checkbox"/> Emetrol Syrup (nausea) | <input type="checkbox"/> Antifungal cream |
| <input type="checkbox"/> Kaopectate or ImodiumAD | <input type="checkbox"/> Milk of Magnesia (magnesium hydroxide) |
| <input type="checkbox"/> Tums or Gaviscon | <input type="checkbox"/> Dextromethineorphan (cough medicine_ |
| <input type="checkbox"/> Neosporin (triple antibiotic) | <input type="checkbox"/> Advil (ibuprofen) |
| <input type="checkbox"/> Benadryl (diphenhydramine) | <input type="checkbox"/> Tylenol (acetaminophen) |
| <input type="checkbox"/> Hydrocortisone cream or spray | <input type="checkbox"/> Chloresceptic spray or lezenges (sore throat) |
| <input type="checkbox"/> Aspirin (sunburn only) | <input type="checkbox"/> Sports cream (muscle soreness) |
| <input type="checkbox"/> Medicated powder | <input type="checkbox"/> Aloe vera (sunburn) |

I give permission for the above circled over the counter medications to be administered to my daughter while at camp.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE THIS FORM WAS SIGNED