# GIRL SCOUTS HEART of the HUDSON - DAY CAMP GIRL HEALTH RECORD

| Name (Last, First, Initial) | Parent or Guardian | | |
|---|---|---|---|
| Address | City | State | Zip |

| Mom's Home (____)_____ | Dad's Home (____)_____ | Date of Birth | Age | Sex |
|---|---|---|---|---|
| Mom's Cell (____)_____ | Mom's Work (____)_____ | | | ☐ Female |
| Dad's Cell (____)_____ | Dad's Work (____)_____ | | | ☐ Male |

| Emergency Contact Person & Relationship to Camper (Not yourself, we always try parents/guardian first!) | Home Phone (____)_____ |
|---|---|
| | Cell Phone (____)_____ |
| | Work Phone (____)_____ |
| Child's Physician:_____ Phone: (____)_____ | |

☐ Rocky Brook

☐ Birch Ridge

☐ Addisone Bovce

**Allergies**: ☐ No Known Allergies

☐ To foods (list):

☐ To medications (list):

☐ To the environment (insect stings, hay fever, etc. – list):

Other allergies (list):

*Describe previous reactions:*

**Diet, Nutrition**: ☐ Eats a regular diet. ☐ This camper eats a regular vegetarian diet.

☐ This camper has special food needs. (Please describe below.)

**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.)

Is the participant covered by family medical/hospital/prescription insurance? 0 Yes 0 No

**Photocopy of front and back of all health insurance cards must be attached to this form.**

**Sign Here**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has my permission to engage in all prescribed camp activities, except as noted by me and/or a physician. I give permission to the physician selected by the camp and/or his designated associates 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. 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 staff about my child's health status. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian _____ Date _____

Office Use Only

_____

_____

_____

| Office Use Only | |
|---|---|
| Insurance | |
| Parent Signature | |
| Med HX 6th months | |
| Camper Confidential | |
| Immuno HX | |

General Health **History:** **Check "Yes" or "No" for each statement. Please explain "Yes" answers.**

Has/does the camper:

1. Ever been hospitalized? Date:_____ . . . . . ☐ Yes ☐ No
2. Ever had surgery? Date:_____. . . . . ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? . . . . . ☐ Yes ☐ No
4. Had a recent infectious disease? Date:_____ Disease:_____. . . . . ☐ Yes ☐ No
5. Had a recent injury? Date: _____ Injury:_____ . . . . . ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? . . . . . ☐ Yes ☐ No
7. Have diabetes? . . . . . .. ☐ Yes ☐ No
8. Had seizures? Last seizure:_____ . . . . . ☐ Yes ☐ No
9. Had headaches or migraines? . . . . . .. ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? If so, what type? _____ . . . . . .. ☐ Yes ☐ No
11. Wear hearing aids or have hearing problems? . . . . . ☐ Yes ☐ No
12. Had fainting or dizziness? . . . . . ☐ Yes ☐ No
13. Passed out/had chest pain during exercise? . . . . . .. . . . . .. . ☐ Yes ☐ No
14. Had mononucleosis ("mono") during the past 12 months? Date:_____ . . . . . ☐ Yes ☐ No
15. Have problems with periods/menstruation? . . . . . ☐ Yes ☐ No
16. Have a problem with falling asleep/sleep walking? . . . . . ☐ Yes ☐ No
17. Ever had back/joint problems? If so, what joint?_____ . . . . . ☐ Yes ☐ No
18. Have a history of bedwetting? . . . . . .. . ☐ Yes ☐ No
19. Have problems with diarrhea/constipation? . . . . . ☐ Yes ☐ No
20. Have any skin problems? If so, what type? _____. . . . . ☐ Yes ☐ No
21. Traveled outside the country in the past 9 months? Date and place: _____. . . . . ☐ Yes ☐ No

**If you would like to provide any additional information regarding the above responses, please use the space provided below.**

#_____

#_____

#_____

#_____

#_____

**Please list any or all medications being taken including name, dosage, and time usually taken:**

1_____

2_____

3_____

If any medication needs to be dispensed at camp, the enclosed medication sheet must be filled out and signed by both a parent and a physician.

**Mental, Emotional, and Social Health:** **Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has the camper:

A. Ever been diagnosed with Attention Deficit Disorder?. . . . . ☐ Yes ☐ No
B. Ever been diagnosed with Attention Deficit Hyperactivity Disorder? . . . . . ☐ Yes ☐ No
C. Ever been treated for emotional or behavioral difficulties or an eating disorder? . . . . . ☐ Yes ☐ No
D. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
E. Had a significant life event that continues to affect the camper's life? . . . . . ☐ Yes ☐ No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others.)

**Please explain "Yes" answers in the space below, noting the number of the questions.**
**The camp may contact you for additional information.**

#_____

#_____

#_____

#_____

GIRL SCOUTS HEART OF THE HUDSON, INC.

CAMPER CONFIDENTIAL TO BE FILLED OUT BY PARENT OR GUARDIAN

Two copies of this page are required; one is kept with the medical records and one given to the Unit Staff.

CAMPER'S FULL NAME: _____
Last First Middle

GRADE IN FALL: _____ CAMP PROGRAM: _____

We earnestly desire to have our camp offer your child the happiest, most beneficial experience possible. Please answer the following questions regarding your child's interests and abilities.

1. Does your camper have any allergies (food, medication, insects, etc.)? _____
2. Does your child have asthma? _____
3. Does your camper have any food restrictions? _____
4. What is your child's eating habits? _____
5. Does your child have any fears? _____
6. No. of brothers_____Ages_____No. of sisters_____Ages_____
7. What is your child's physical activity level? High _____ Medium _____ Low _____
8. Is your child easily frustrated? _____
9. How does your child express emotions? _____
10. What does sad look like? Frustrated? Mad? _____
    _____
11. How does your child respond to change? _____
12. Is your child sensitive to sight, sound or touch? _____
13. Would you characterize your child as flexible? _____
14. Is your child easily distracted? _____
15. What are your child's special abilities? _____
16. What are your child's hobbies? _____
17. Does your child wet the bed? _____

Please repeat on this page any items from your camper's health history that her councilors should be aware of. Be sure to include asthma, allergies, seizure disorders, medications, learning disabilities, behavioral patterns, emotional sensitivities, restricted mobility and any other pertinent information.

In what way did previous camp experience benefit your child?_____
_____

What do you hope your child gains from her camp experiences this year?_____
_____

Has any recent event affected your child in a way that might make her unhappy away from home? (such as death of a pet, parent away on long tip, impending or recent move, separation of parents, etc.) _____
_____
_____

Additional Comments: _____
_____
_____
_____
_____

Relationship to camper: _____Signature_____

Immunization History: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please return with this form.

| Immunization | Dose 1 Month/Year | Dose 2 Month/Year | Dose 3 Month/Year | Dose 4 Month/Year | Dose 5 Month/Year | Most Recent Dose Month/Year |
|---|---|---|---|---|---|---|
| Diphtheria, tetanus, pertussis* (DTap) or (TdaP) | | | | | | xxxxxxxxxxx |
| Tetanus booster* (dT) or (TdaP) | xxxxxxxxxxx | xxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx | |
| Mumps, measles, rubella (MMR) | | | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx | |
| Polio (IPV) | | | | | xxxxxxxxxxx | xxxxxxxxxxx |
| Haemophilus influenzae type B (HIB) | | | | | xxxxxxxxxxx | xxxxxxxxxxx |
| Pneumococcal (PCV) | | | | | xxxxxxxxxxx | xxxxxxxxxxx |
| Hepatitis B | | | | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx |
| Hepatitis A | | | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx |
| Varicella (chicken pox) ☐ Had disease Date: | | | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx |
| Meningococcal meningitis | | xxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx | xxxxxxxxxxx |

*A Tetanus shot given within 10 years is required.

| Tuberculosis (TB) test | Date: | ☐ Negative | ☐ Positive |
|---|---|---|---|