GIRL SCOUTS HEART of the HUDSON - RESIDENT 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 (____)_____

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 permission to engage in all prescribed activities, except as noted by me and/or the examining 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 _____

PLEASE RETURN ALL MEDICAL FORMS TO:
JAMIE JAKUBIK NO LATER THAN MONDAY JUNE 16TH, 2014.
Email: jjakubik@girlscoutshh.org
New City Fax: 845-638-2804
Or Mail to: 211 Red Hill Road, New City, NY 10956
YOUR CHILD WILL NOT BE ALLOWED TO ATTEND CAMP IF ALL FORMS ARE NOT COMPLETED AND TURNED IN.

General Health History: **Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

1. Ever been hospitalized? . . . . . ☐ Yes ☐ No
2. Ever had surgery? . . . . . ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? . . . . . ☐ Yes ☐ No
4. Had a recent infectious disease? . . . . . ☐ Yes ☐ No
5. Had a recent injury? . . . . . ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? . . . . . ☐ Yes ☐ No
7. Have diabetes? . . . . . ☐ Yes ☐ No
8. Had seizures? . . . . . ☐ Yes ☐ No
9. Had headaches? . . . . . ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? . . . . . ☐ 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? . . . . . ☐ Yes ☐ No
15. If female, have problems with periods/menstruation? . . . . . ☐ Yes ☐ No
16. Has begun menstruation? . . . . . ☐ Yes ☐ No
17. Uses tampons? . . . . . ☐ Yes ☐ No
18. Have a problem with falling asleep/sleep walking? . . . . . ☐ Yes ☐ No
19. Ever had back/joint problems? . . . . . ☐ Yes ☐ No
20. Have a history of bedwetting? . . . . . ☐ Yes ☐ No
21. Have problems with diarrhea/constipation? . . . . . ☐ Yes ☐ No
22. Have any skin problems?. . . . . ☐ Yes ☐ No
23. Traveled outside the county in the past 9 months? . . . . . ☐ Yes ☐ No

Please explain "Yes" answers in the space below as necessary, noting the number of the questions.
For travel outside the country, please name countries visited and dates of travel.
If your daughter has diabetes include a copy of the Medical Management Plan for review.

#_____

#_____

#_____

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

Has the camper:

1. Ever been diagnosed with attention deficit disorder (ADD) or ADHD? . . . . . ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? . . . . . ☐ Yes ☐ No
3. During the past 6 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. 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, etc)

5. During the past 6 months had a severe emotional or traumatic experience? . . . . . ☐ Yes ☐ No
6. Ever engaged in cutting, self-mutilation, or self-harm? . . . . . ☐ Yes ☐ No
7. Ever attempted or spoken about attempting suicide? . . . . . ☐ Yes ☐ No

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

#_____

#_____

#_____

#_____

MANDATORY FORM: This form MUST be filled in by physician after review of Health History with Parent/Guardian. This form is necessary even if NO over the counter medications are permitted.

Name:_____ Date of birth;_____

STANDING ORDERS

RESIDENT SUMMER CAMP OVER THE COUNTER MEDICATION FORM

The Resident Summer Camp Programs will stock the following medications. They can only be given to your child if this form is signed by both the parent/guardian and a physician. A physician must sign this form even though these are over the counter medications! The column titled "Camper Health Care Provider Order" must be circle yes for your child to receive a medication.

Drug Name	Route (please circle preferred formulation (s))	Dosage	Schedule and Indications	Camper Health Care Provider Order	Comments
Acetaminophen (Tylenol)	PO (elixir or tab)	Per label instructions by age/weight	Q 4 hr pm for pain or fever >___degrees F	Yes No	
Ibuprofen (Advil, Motrin)	PO (elixir or tab)	Per label instructions by age	Q 6 hr pm for pain or fever >___degrees F	Yes No	
Pseudoephedrine (Sudafed)	PO (elixir or tab)	Per label instructions by age	Q 6 hr pm for nasal congestion	Yes No	
Diphenhydramine (Benadryl)	PO (fast melt, strips, elixir, or tab)	Per label instructions by age/weight	Q 6 hr pm for allergic reaction (hives, insect bite)	Yes No	
Loradine (Claritin)	PO (elixir or tab)	Per label instructions by age	Q 24 hr pm for allergies	Yes No	
Generic cough drops	PO	1 cough drop	Q 4 hr pm for sore mouth or throat	Yes No	
Dextromethorphan cough syrup (Robitussin DM)	PO (syrup)	Per label instructions by age	Q 4 hr for cough	Yes No	
Loperamide (Imodium A-D)	PO (chewable tab or tab)	Per label instructions by age	As directed on package pm for diarrhea	Yes No	
Tums	PO (chewable tab)	Two tablets	Q 4 hr pm for upset stomach	Yes No	
Anbesol	Liquid or gel topical to inside the mouth	Apply to affected area	QID for mouth or tooth pain	Yes No	
Lice shampoo	Topical	Apply to hair and scalp as directed on package	1 time for active lice	Yes No	
Calamine lotion	Topical	Apply to affected area	Q 4 hr pm for bug bites or poison ivy	Yes No	
Band-Aid Anti Itch Gel or Spray	Topical	Apply to affected area	Q 4 hr pm for bug bites or poison ivy	Yes No	
Ivy Dry	Topical	Apply to affected area	Q 4 hr pm for poison ivy	Yes No	
Topical antibiotic cream	Topical	Apply to affected area	Q 4 hr pm for minor cuts, scrapes, burns	Yes No	
Hydrocortisone 1% cream	Topical	Apply to affected area	QID for skin inflammation or irritation	Yes No	
Anti-fungal spray or cream	Topical	Apply to affected area	BID for itching, burning, scaling feet	Yes No	
Aloe or burn spray	Topical	Apply to affected area	QID for sunburn	Yes No	
Swim Ear	Ear Drops	4 drops in effected ear	1 time after swimming to dry ear.	Yes No	

_____ _____

Date Parent/ Guardian Signature

_____ _____

Date Physician's Signature

Physician's Stamp

This Section to be filled in by physician after review of Health History with Parent/Guardian.
Standard Physician office form may be substituted for this information.

Camper Name: _____

Physical exam done today: ☐ Yes ☐ No If "No", date of last physical: _____ Must be within 12 months of the start of camp. Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____/_____	Diet, Nutrition: ☐Eats a regular diet. ☐Has a medically prescribed meal plan or dietary restrictions: (describe below)
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:	**The camper is undergoing treatment at this time for the following conditions:** (describe below) ☐ None.
Medication: ☐ No daily medications. ☐ Will take medications while at camp. Document these on the medication form.	**Other treatments/therapies to be continued at camp:** (describe below) ☐ None needed
Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes If you answered "Yes" to the question above, what do you recommend? (describe – attach additional information if needed)	

Immunization History: Provide the **day, 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 Date/Month/Year	Dose 2 Date/Month/Year	Dose 3 Date/Month/Year	Dose 4 Date/Month/Year	Dose 5 Date/Month/Year	Most Recent Dose Date/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

The camp staff will treat SEVERE ALLERGIC REACTION such as insect stings, drug sensitivity, food reaction, etc. as follows: Determine the cause if possible. Call for medical assistance immediately. Administer Benadryl. See label for dosage by weight and age. If anaphylaxis is impending, due to severe allergic reaction and camper's weight is 66 lbs. or less, administer Epi-Pen Jr. If larger, use regular Epi-Pen. Transport to hospital by ambulance if available.

"I have reviewed the CAMPER HEALTH HISTORY FORM, and have discussed the camp program with the camper's parent/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Physician's Signature _____ Date _____

Stamp with address and phone number

GIRL SCOUTS HEART OF THE HUDSON, INC.
CAMPER CONFIDENTIAL TO BE FILLED OUT BY PARENT OR GUARDIAN

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 trip, impending or recent move, separation of parents, etc.) _____
_____
_____

Additional Comments: _____
_____
_____
_____
_____

Relationship to camper: _____Signature_____

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Dear Rock Hill Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Health Law (NYS PHL) §2167 and Subpart 7-2 of the State Sanitary Code requires overnight children's camps to distribute information about meningococcal disease and vaccination to all campers who attend camp for 7 or more consecutive nights.

Rock Hill is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal disease and vaccine information signed by the camper's parent or guardian; AND EITHER
- A record of meningococcal meningitis immunization OR
- An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningococcal meningitis is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,000-1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10-15% of these people die. Of those who live, another 11%-19% lose their arms or legs, have problems with their nervous systems, become deaf, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16-21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

Thank you for your cooperation,

Please do not hesitate to contact us with any questions,

Katrina Dearden
Rock Hill Camp Director
kdearden@girlscoutshh.org

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MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

Check one box and sign below:

☐ My child has had the meningococcal conjugate vaccine (MCV4), for example Menactra or Menveo.

Date received: _____

[Note: The Centers for Disease Control and Prevention (CDC) recommend two doses of MCV4 for all adolescents 11 through 18 years of age; the first dose at 11 or 12 years of age, with a booster dose at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, the booster is not needed.]

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____
(Parent / Guardian)

Camper's Name: _____ Date of Birth: _____

Mailing Adress:_____

Parent/Guardian's Email address (optional): _____

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Rock Hill Camp
Activity Permission

We offer many activities at camp to help our campers explore the outdoors, learn about themselves and have fun! While at camp the girls will swim, boat, hike, play games, craft, cook outdoors, try archery, explore our ropes course, and attend campfires in addition to all of the program activities for their session.

For each activity the girls will be supervised by both their unit staff and specialists. While at the lake, they are guarded by American Red Cross certified lifeguards, our archery instructor is National Field Archery Association certified, and Unit Staff receives first aid and CPR training.

Please indicate below if there are any activities that you would prefer your daughter NOT to participate in.

Camper's Name: _____

☐ I would prefer that my daughter not participate in _____.
Parent Signature

☐ My daughter may participate in all camp activities. _____
Parent Signature

Ropes Course Activity Permission

Our camp offers a ropes program. We offer our younger campers a chance to do ropes games which build teamwork and encourage leadership, and our older campers a chance to complete initiatives on our low and high ropes courses and zipline. Our course and equipment is inspected yearly and the staff that oversees these activities goes through an annual training. While on the course participants wear helmets and harnesses.

Camper's Name: _____

☐ I give permission for my daughter to participate in these activities. _____ _____
Parent Signature Date

☐ I **DO NOT** give permission for my daughter to participate in these activities. _____ _____
Parent Signature Date

Sunscreen Permission

☐ I give permission for my daughter to carry and apply her own sunscreen_____ _____
Parent Signature Date

☐ I **DO NOT** give permission for my daughter to carry and apply her own sunscreen _____ _____

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GIRL SCOUT SUMMER CAMP MEDICATION FORM

Name: _____ Date of birth: _____

THIS FORM MUST INCLUDE ALL MEDICATIONS A CAMPER NEED TO BE GIVEN. (This includes over the counter and prescription medications, and vitamins, salves, ointments, drops, etc.) The form and medication will be collected by the Camp Health Manager. Campers are NOT allowed to keep any medication in units. Any medication brought to camp WILL NOT be given unless this form has been COMPLETED.

The form must be signed both by the parent/guardian and a physician. A physician must sign this form even if your child is only taking over the counter medications!

MEDICATION NAME AND DOSAGE	WHEN TAKEN (SPECIFIC TIMES)	FOR WHAT PURPOSE

The administration of this medication may be supervised by the Camp Director, Assistant Director or Unit Leader if the Health Manager is unavailable: Yes ( ) No ( )

_____ _____
Date Parent/ Guardian Signature

_____ _____
Date Physician's Signature

Physician's Stamp

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Girl Scout Camp Asthma Form

Name: _____ **Date of Birth:** _____

What triggers your asthma? Please check all that apply and provide details about the trigger, including things the staff should be told.

( ) Exercise _____
( ) Fatigue_____
( ) Dehydration_____
( ) Stress__ _____
( ) Food item_____
( ) Smoke__ _____
( ) Respiratory infections/ common cold_____
( ) Allergen_____
( ) Other _____

Using a Peak Flow Meter

We recommend using a peak flow meter as a way to monitor your asthma and note signs of a potential flare before it is well established. **Please bring your peak flow meter to camp.**

When do you take peak flow readings?

( ) Breakfast ( ) Lunch ( ) Supper ( ) Bedtime ( ) Other _____

Routine peak flow reading (green zone) _____
Caution range (yellow zone) _____
What is done if the peak flow readings drop to the caution/ yellow range?_____
_____
Danger range (red zone) _____
What is done if peak flow reading drops to the danger/ red zone? _____
_____

Nebulizer Treatment and Use

Will you bring a nebulizer to camp? ( ) Yes ( ) No
If yes, do you know when you need your nebulizer? ( ) Yes ( ) No
What medication is used via nebulizer? _____

Administration of Medication

The administration of the medications may be supervised by the Camp Director or Unit Leader if the Health Supervisor is unavailable.

( ) Yes ( ) No

About Medications:

These medications are used daily to manage asthma.

Medication Name	Dose Given	When	Reason for Using this Medication

These medications are taken 'as needed' to prevent an asthma flare.

Medication Name	Dose Given	When	Reason for Using this Medication

These medications are used when asthma flares.

Medication Name	Dose Given	When	Reason for Using this Medication

Emergency medications must be portable! Nebulizers that require electricity are not practical for many camp trips. Please call the Camp Health Manager if you have any questions.

_____ _____

Date Parent/ Guardian Signature

_____ _____

Date Physician's Signature

Physician's Stamp

This form may be substituted for the medication form for asthma medications. A medication form must be completed for all medications a camper needs to be given (including vitamins, salves, ointments, srops, etc.)