

RESIDENT CAMP GIRL HEALTH EXAMINATION RECORD

Name (Last, First, Initial)		Parent or Guardian			
Address		City	State	Zip	
Mom's Home	() _____	Dad's Home	() _____	Date of Birth	Age
Mom's Cell	() _____	Mom's Work	() _____		Sex Female Male
Dad's Cell	() _____	Dad's Work	() _____		
Emergency Contact Person & Relationship to Camper (Not yourself, we always try parents/guardian first!)		Home Phone	() _____		
		Cell Phone	() _____		
		Work Phone	() _____		

0 Ludington

0 Rock Hill

0 Wendy

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 _____

Office Use Only

Office Use Only	
Med HX 6 th months	
Parent Signature	
PE 2 years	
Immuno HX	
Standing Order	
MD Stamp	
MD Signature	
Camper Confidential	
Meningitis Response	
Insurance	

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

Has/does the camper:

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

Please explain "Yes" answers in the space below, nothing the number of the questions. For travel outside the country, please name countries visited and dates of travel.

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 (ADD) or AD/HD? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Ever been treated for emotional or behavioral difficulties or an eating disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. During the past 12 months, seen a professional to address mental/emotional health concerns? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Had a significant life event that continues to affect the camper's life? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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, nothing 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 _____

**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.**

Physical exam done today: <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", date of last physical: _____ Must be within 24 months of the start of camp. Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____	Diet, Nutrition: <input type="checkbox"/> Eats a regular diet. <input type="checkbox"/> Has a medically prescribed meal plan or dietary restrictions: (describe below)
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Allergies: <input type="checkbox"/> No Known Allergies <input type="checkbox"/> To foods (list): <input type="checkbox"/> To medications (list): <input type="checkbox"/> To the environment (insect stings, hay fever, etc. – list): <input type="checkbox"/> Other allergies (list): Describe previous reactions:	The camper is undergoing treatment at this time for the following conditions: (describe below) <input type="checkbox"/> None.
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Medication: <input type="checkbox"/> No daily medications. <input type="checkbox"/> Will take medications while at camp. Document these on the medication form.	Other treatments/therapies to be continued at camp: (describe below) <input type="checkbox"/> None needed
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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 below – attach additional information if needed)

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)						xxxxxxxxxx
Tetanus booster* (dT) or (Tdap)	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	
Mumps, measles, rubella (MMR)			xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	
Polio (IPV)					xxxxxxxxxx	xxxxxxxxxx
Haemophilus influenzae type B (HIB)					xxxxxxxxxx	xxxxxxxxxx
Pneumococcal (PCV)					xxxxxxxxxx	xxxxxxxxxx
Hepatitis B				xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Hepatitis A			xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Varicella (chicken pox)	<input type="checkbox"/> Had disease Date: _____		xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Meningococcal meningitis		xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx

***A Tetanus shot given within 10 years is required.**

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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The camp staff will treatment 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