GIRL/ADULT HEALTH RECORD FOR CAMP

This form is required for Overnight Camp, Day Camp, trips of 3 days or more, and certain adventure activities.
Overnight Campers must have this form completed by a physician.
Day Campers may have the form completed by a parent/guardian. Physician signature is not required.
Fill out all sections completely. Indicate None or Does Not Apply as necessary.

A. Participant Name (Last, First, Initial)	Name and relationship of parent/guardian completing this form			Phone		
Address (Street & Number)	City or Town	State	Zip Code	Date of Birth	Age	Sex

B. EMERGENCY/TRANSPORTATION CONTACT – Must include parent/guardian or person completing form.
Relationship Key: M=Mother, SM=Stepmother, F=Father, SF=Stepfather, GP=Grandparent, O=Other

NAME	RELATIONSHIP	DAY PHONE	EVENING PHONE	CELL PHONE	THIS PERSON IS ANEMERGENCY CONTACT	MY GIRL SCOUT MAYBE RELEASED TO THIS PERSON
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

Physician's name________________________Phone (___)____________ Dentist's name_____________________Phone (___)____________

Are there any legal custodial issues we should be aware of? ☐ Yes ☐ No

If yes, please explain. ___________________________

C. HEALTH HISTORY – To be completed by parent/guardian. Check all that apply. Please contact the camp director before the start of camp if you would like to discuss any accommodations or needs to ensure your camper is successful at camp. Explanations of any items checked should be added at the end of this section sections F & G.

ALLERGIES (Complete reverse side.)	DISEASES	CHRONIC OR RECURRING ILLNESS	OTHER HEALTH CONDITIONS	
❒ Animals	❒ Chicken pox	❒ Asthma	❒ ADD/ADHD	❒ Frequent stomach aches
❒ Food	❒ Eating disorder	❒ Bleeding disorders	❒ Anxiety	❒ Hearing impairment
❒ Hay fever/Pollen	❒ German measles	❒ Diabetes Type 1	❒ Bedwetting	❒ Learning disability
❒ Insect stings	❒ Measles	❒ Diabetes Type 2	❒ Behavioral disturbances	❒ Menstrual cramps
❒ Medicine/Drugs	❒ Mononucleosis	❒ Ear Infections	❒ Constipation	❒ Motion sickness
❒ Plants	❒ Mumps	❒ Heart defect/disease	❒ Depression	❒ Night terrors
❒ Other (Specify)	❒ Other (Specify)	❒ Hypertension	❒ Diarrhea	❒ Nosebleeds
		❒ Kidney disease	❒ Emotional disturbances	❒ Pediculosis (lice)
		❒ Musculoskeletal disorders	❒ Fainting	❒ Sleepwalking
		❒ Seizures/Epilepsy	❒ Frequent colds	❒ Wears glasses/contacts
		❒ Sickle Cell Anemia	❒ Frequent headaches	❒ Wears orthodontic devices
		❒ Sinusitis	❒ Frequent sore throats	❒ Other (specify)
		❒ Tuberculosis		
		❒ Other (specify)		

In the past year has your camper had:
- ❒ an injury/illness requiring medical attention
- ❒ a surgical operation or fracture
- ❒ restrictions from participation in physical education
- ❒ an illness lasting longer than 5 days
- ❒ hospital treatment
- ❒ exposure to contagious disease

Is your camper currently:
- ❒ receiving psychological counseling
- ❒ under a physician's care
- ❒ restricted in physical activity
- ❒ taking prescription medication (Complete reverse side.)
- ❒ taking over the counter medication (Complete reverse side.)
- ❒ taking no medication on a routine basis

Please explain any items checked on the lines below. Include dates and any information that would be helpful to camp staff in relation to these health conditions. Add a separate sheet if needed. Allergies and medications should be explained on reverse side.

____

____

D. OTHER INFORMATION

Height; _____________Weight:_____________

Specify any special dietary regimen to be followed:

Specify activities to be encouraged:

Specify activities to be restricted:

List necessary adaptations or limitations:

Has your camper been taught about menstruation?

☐ Yes ☐ No

Has your camper begun menstruation?

☐ Yes ☐ No

E. PERMISSION TO TREAT
My camper has permission to take or use the following:

- ❒ Advil/Ibuprofen
- ❒ Midol
- ❒ Tylenol/acetaminophen
- ❒ Calamine/Cala-gel/Aloe gel
- ❒ Hydrocortisone cream
- ❒ Neosporin
- ❒ Benadryl/antihistamine (oral)
- ❒ Robitussin/expectorant
- ❒ Sudafed/decongestant
- ❒ Cough Drops
- ❒ Chloraseptic/Throat spray
- ❒ Tums/Maalox/Mylanta/antacid
- ❒ Kaopectate/anti-diarrheal
- ❒ Milk of Magnesia/laxative
- ❒ Swimmer's Ear/alcohol
- ❒ Eye drops
- ❒ Other _______________

This health record, including the allergy and medication information on the reverse side, is complete and accurate. My camper has my permission to engage in all prescribed activities, including strenuous activities such as hiking, swimming, climbing hills, and horseback riding (if applicable), except asnoted by me and the examining physician.

I give my permission for the camp staff to obtain in-camp or out-of-camp medical treatment for my camper should the need arise while they is at camp. In case of emergency, if none of the above can be contacted, I consent to treatment for my camper under the supervision of and as deemed advisable bya physician licensed under the Medicine Practice Act. If my camper is out of camp on a trip, I will not be contacted before medical treatment is given.

HEALTH INFORMATION PRIVACY STATEMENT
The **Girl/ Adult Health Record for Camp** is for health care concerns at Girl Scout day camp or resident camp sessions only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health service supervisor at the camp. Minimal necessary information may be shared with other staff/volunteers in order to provide adequate participant safety and health care. Girl Scouts of Central Illinois, will retain the health form until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature of Parent/Guardian_______________________________Date

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F. MEDICATION INFORMATION – To be completed by the parent/guardian. Your camper's over-the-counter and prescription medications will need to be brought with them to camp in the original containers with their correct label and dosage information. Attach a separate sheet if necessary.

Medication	Condition Treated	Dosage	Time of Day	Taken With Food
			❒ Breakfast ❒ Lunch ❒ Dinner ❒ Bedtime ❒ Other _________	❒ Yes ❒ No
			❒ Breakfast ❒ Lunch ❒ Dinner ❒ Bedtime ❒ Other _________	❒ Yes ❒ No
			❒ Breakfast ❒ Lunch ❒ Dinner ❒ Bedtime ❒ Other _________	❒ Yes ❒ No
			❒ Breakfast ❒ Lunch ❒ Dinner ❒ Bedtime ❒ Other _________	❒ Yes ❒ No

PARTICIPANT NAME (LAST, FIRST, INITIAL) ________________________________

G. ALLERGIES – To be completed by the parent/guardian. List all known allergies. Attach a separate sheet if necessary.

MEDICATION ALLERGIES	REACTION OR SYMPTOMS	MANAGEMENT OR TREATMENT

FOOD ALLERGIES	REACTION OR SYMPTOMS	MANAGEMENT OR TREATMENT

OTHER ALLERGIES (animals, hay fever, etc)	REACTION OR SYMPTOMS	MANAGEMENT OR TREATMENT

H. DOCTOR'S APPROVAL TO SELF-ADMINISTER INHALERS

Please allow________________________to self-administer their inhaler.________________________has asthma and understands how to use the inhaler, since they has been self-administering the inhaler for some time. (In the past, nurses kept the inhalers in their office, but the law has changed since Governor Ryan signed SB979 into law amending the School Code to require a school to permit the student to self-administer.)

________________________________ ________________________________

Doctor Signature and Date Parent/Guardian Signature and Date

I. IMMUNIZATIONS

An immunization record is required for all day camp and overnight campers. Immunizations should meet current requirements for public school attendance in Illinois. The record may be completed by a physician or you may attach a current copy of your immunization record.

IMMUNIZATIONS	YEAR PRIMARY SERIES COMPLETED	YEAR OF LAST BOOSTER
Diphtheria		
DTP/DTaP		
Hepatitis B		
HIB (Hemophilus influenza b)		
Measles		
Oral polio		
Pertussis (Whooping Cough)		
Rubella		
TD (Adult tetanus-diphtheria toxoid)		
Tetanus		______ (w/in last 10 yrs)
Tuberculin test	Year last given______ Result ________	
COVID-19		
Other		

PHYSICIAN DOCUMENTATION

Physician documentation is required for overnight camps or trips of 3 nights or more. It is not required for day camps. Complete all sections as well as the immunization record on page 3. Required health exam must be completed by a licensed physician, nurse practitioner, physician's assistant, or registered nurse with 24 months prior to the start of the camp session.

B. HEALTH EXAMINATION

Patient's first and last name ______________________________ Height__________ Weight__________ Blood Pressure__________

EYES – Without Glasses R 20/_____ L 20/_____ With Glasses R 20/_____ L 20/_____ EARS – Hearing R __________ Hearing L __________

ORGANS, ETC.	SATISFACTORY	NOT SATISFACTORY	NOT EXAMINED
Abdomen			
Color vision			
General physical and emotional status			
Genitalia			
Heart			
Hernia			
HGB *			
Lungs			
Musculoskeletal			
Nose			
Skin			
Teeth			

* Not required for every health examination. A Girl Scout in grades K-6 should have this test if they have not already had it, either when entering school or at any time since. A Girl Scout in grades 7-12should have this test if they have not had it since entering puberty.

K. PHYSICIAN'S COMMENTS AND RECOMMENDATIONS

Note any restrictions, limitations, needed adaptations, and/or guidelines for care and treatment of health conditions. Give details or indicate management of significant illness. ______________________________

L. LICENSED PHYSICIAN'S RELEASE

This person is in satisfactory condition and may engage in all prescribed activities, including strenuous activities such as hiking, swimming, climbing hills, and horseback riding (if applicable), except as noted.

Physician's signature ______________________________ Date of physician's signature __________ Date of patient's last health examination _______

Physician's name (please print) ______________________________ Facility/Office name ____________________ Phone (_______)_______________

Facility address ______________________________ City ____________________ State __________ Zip ____________

Department: Program	Approved by: COO Operational Services
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