girl scouts of central illinois

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

**In the past year has your daughter 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 daughter 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.

_____

_____

**Continued on Next Page**

**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 daughter been taught about menstruation? ☐ Yes ☐ No

Has your daughter begun menstruation? ☐ Yes ☐ No

**E.** PERMISSION TO TREAT

My daughter 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 daughter 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 daughter should the need arise while she is at camp. In case of emergency, if none of the above can be contacted, I consent to treatment for my daughter under the supervision of and as deemed advisable bya physician licensed under the Medicine Practice Act. If my daughter 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

**F.** MEDICATION INFORMATION – To be completed by the parent/guardian. Your daughter's over-the-counter and prescription medications will need to be brought with her 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 ❒ Bedtime<br>❒ Lunch ❒ Other _____<br>❒ Dinner | ❒ Yes<br>❒ No |
| | | | ❒ Breakfast ❒ Bedtime<br>❒ Lunch ❒ Other _____<br>❒ Dinner | ❒ Yes<br>❒ No |
| | | | ❒ Breakfast ❒ Bedtime<br>❒ Lunch ❒ Other _____<br>❒ Dinner | ❒ Yes<br>❒ No |
| | | | ❒ Breakfast ❒ Bedtime<br>❒ Lunch ❒ Other _____<br>❒ Dinner | ❒ Yes<br>❒ No |

**Continued on Next Page**

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 her inhaler._____has asthma and understands how to use the inhaler, since she 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 (Haemophilus influenza b) | | |
| Measles | | |
| Oral polio | | |
| Pertussis (Whooping Cough) | | |
| Rubela | | |
| 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.

## J. 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 she has not already had it, either when entering school or at any time since. A Girl Scout in grades 7-12should have this test if she has 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 _____