



# GIRL/ADULT HEALTH RECORD

This form is required for Resident Camp, Day Camp and trips of 3 days or more.

\*\*Fill out all sections completely. Indicate None or Does Not Apply as necessary.

This form is required annually for each girl participating in a Girl Scout day camp and/or resident camp program.

ADMINISTRATIVE USE ONLY:  
 Program Name \_\_\_\_\_  
 Session Number \_\_\_\_\_ Dates \_\_\_\_\_

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 DAUGHTER MAY BE RELEASED TO THIS PERSON.
		( )	( )	( )	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
		( )	( )	( )	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
		( )	( )	( )	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
		( )	( )	( )	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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.

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

In the last 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, give dates, and include 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**

Has your daughter been taught about menstruation?  Yes  No Specify activities to be encouraged \_\_\_\_\_

Has your daughter begun menstruation?  Yes  No Specify activities to be restricted \_\_\_\_\_

Specify any special dietary regimen to be followed \_\_\_\_\_ List necessary adaptations or limitations \_\_\_\_\_

**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  
 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 as noted 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 by a 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 \_\_\_\_\_

Continued on Back Side

Department: Program	Approved by: COO Operational Services
To Be Reviewed: September	Last Reviewed: April 2009
Last Revised: April 2009	Revision Number: 1

PARTICIPANT NAME (LAST, FIRST, INITIAL) \_\_\_\_\_

DATE \_\_\_\_\_

**F. 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	REACTION OR SYMPTOMS	MANAGEMENT OR TREATMENT
(insect stings, hay fever, asthma, animal dander, etc.) _____	_____	_____
_____	_____	_____

**G. 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
_____	_____	_____	o 7:45 a.m. o 12:15 p.m. o 6:00 p.m. o Bedtime o As needed o Other _____	o Yes o No
_____	_____	_____	o 7:45 a.m. o 12:15 p.m. o 6:00 p.m. o Bedtime o As needed o Other _____	o Yes o No

**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’s Signature and Date \_\_\_\_\_

Parent Signature and Date \_\_\_\_\_

**PHYSICIAN DOCUMENTATION**

- **Day Camp Participants:** Complete section J (immunizations chart) only. Tetanus booster must be current (within 10 years.) No exam is necessary.
- **Resident Camp Participants:** Complete all sections (H-L) below. Required health exam must be completed by licensed physician, nurse practitioner, physician’s assistant, or registered nurse within 24 months prior to camp session. Tetanus booster must be current (within 10 years.)

**H. 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 \_\_\_\_\_

I. ORGANS, ETC.	SATISFACTORY	NOT SATISFACTORY	NOT EXAMINED	J. IMMUNIZATIONS	YEAR PRIMARY SERIES COMPLETED	YEAR OF LAST BOOSTER
Color vision				DTP/DTPaP		
General physical and emotional status				Hepatitis B		
Genitalia				HIB (Haemophilus influenza b)		
Heart				Measles		
Hernia				Oral polio		
HGB *				Pertussis (Whooping Cough)		
Lungs				Rubella		
Musculoskeletal				TD (Adult tetanus-diphtheria toxoid)		
Nose				Tetanus		_____ (w/in last 10 yrs)
Skin				Tuberculin test	Year last given _____	Result _____
Teeth				Other		
Throat				<b>K. PHYSICIAN’S COMMENTS AND RECOMMENDATIONS</b>		
Urinalysis *				Note any restrictions, limitations, needed adaptations, and/or guidelines for care and treatment of health conditions. Give details or indicate management of significant illness. _____ _____ _____		

\* 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 7-12 should have this test if she has not had it since entering puberty.

**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 \_\_\_\_\_