



Resident Camp Health & Safety Record for Girls
BRING THIS FORM TO CAMP

All information required for camp attendance. This form is good for 24 months, must be signed by a parent/guardian AND physician, and must not expire before the last day that the camper is in camp. If you are attending multiple camp sessions, please make a copy of the completed form for each camp.

Camper Name _____ Date of Birth _____ Age _____

Parent/Guardian Name _____

Home Street Address _____

City _____ State _____ Zip Code _____ Phone (H) _____

Email Address _____ Cell Phone _____

PRIMARY PHONE NUMBER IN CASE OF AN EMERGENCY _____

Emergency Contact _____ Relationship _____
Address _____ Phone (H) _____
Email Address _____ Phone (W) _____
Cell Phone _____

Family Physician _____ Phone _____
Insurance Carrier _____ Policy or Group Number _____
Family Dentist _____ Phone _____
Dental Insurance Carrier _____ Policy or Group Number _____

PART ONE: ILLNESS AND INJURIES (CHECK ALL THAT APPLY)

- ___ Frequent Headaches ___ Bleeding/Clotting Disorder ___ Hypertension ___ Asthma
___ Heart Defect/Disease ___ Musculoskeletal Disorder ___ Diabetes ___ Arthritis
___ Immune Disorders ___ Kidney/Bladder Disorder ___ Skin Problems ___ Seizures
___ Stomach/Bowel Disorders ___ Nose/Throat Illnesses ___ Ear infection ___ Other _____
___ Sickle Cell Disease ___ Hearing Impairment ___ Mononucleosis ___ Hepatitis A,B, or C _____

Explain any condition checked: _____

PART TWO: ALLERGIES (CHECK ALL THAT APPLY)

- ___ Medicines/Drugs specify _____ Animals specify _____ Pollen
___ Food specify _____ Plants specify _____ Hayfever
___ Insects specify _____ Other _____

Explain any allergy checked: _____

PART THREE: OTHER RELATED HEALTH CONDITIONS (CHECK ALL THAT APPLY)

- ___ Bed Wetting ___ Constipation ___ Motion Sickness ___ Dental Devices/retainer
___ Nosebleeds ___ Sleep Disturbance ___ Emotional Disturbance ___ Braces
___ Fainting ___ Glasses or Contacts ___ wearing at camp
___ Menstrual Cycle If yes, is her menstrual history normal? Y N Explain _____
If not, has she been told about it? Y N
Special considerations needed? _____

___ Other conditions _____

Explain any conditions checked: _____

CONTINUE ON NEXT PAGE

PART FOUR: To support a successful program, please thoroughly answer the following questions. feel free to add or attach any additional information with this form.

1. Is there anything special that we should know about your child? Such as specific medical condition(s), learning differences, or behavior issues?

2. Does your child have any special dietary needs? ___ Kosher ___ Vegetarian ___ Vegan

3. Does your child need assistance from the staff to participate in camp activities? Please be specific.

4. Is there family information that we should know in order to maintain the health and safety of your child?

5. Is participant currently under the care of a physician or psychologist for other than routine health maintenance?
 Y N If yes, please explain.

PART FIVE: IMMUNIZATION AND DISEASE HISTORY (COMPLETE ALL INFORMATION)

PLEASE GIVE ALL DATES OF IMMUNIZATION (OR IF HAD DISEASE, GIVE DATES) FOR:

<u>VACCINE OR DISEASE:</u>	<u>DATES:</u>	<u>Initial Mo/YR</u>	<u>Booster Mo/YR</u>	<u>Booster Mo/YR</u>	<u>Booster Mo/YR</u>
DTP		_____	_____	_____	_____
TD		_____	_____	_____	_____
Tetanus		_____	_____	_____	_____
Polio		_____	_____	_____	_____
MMR		_____	_____		
or Measles		_____			
or Mumps		_____			
or Rubella (German Measles)		_____			
Haemophilus Influenza B		_____	_____	_____	_____
Hepatitis B		_____	_____	_____	
Varicella (chicken pox)		_____			
Meningococcal (MCV4)		_____			
TB Mantoux Test	Date of last test _____			Result: ___Positive	___Negative

Since last health exam, has participant had:

(Please explain any "yes" responses.)

- | | | | |
|---|---|---|-------|
| A serious injury requiring medical attention? | Y | N | _____ |
| Any prescribed or over-the-counter medications? | Y | N | _____ |
| Treatment in a hospital or emergency room? | Y | N | _____ |
| Any exposure to a contagious disease? | Y | N | _____ |
| An illness lasting more than five days? | Y | N | _____ |
| A surgical operation or fracture? | Y | N | _____ |

PART SIX: MEDICATION INFORMATION:

LIST ALL MEDICATIONS/PURPOSES/DOSAGES. ATTACH AN ADDITIONAL PAGE IF NECESSARY.

ALL PRESCRIPTIVES AND OVER THE COUNTER MEDICATIONS TAKEN REGULARLY MUST BE SENT TO CAMP IN THE ORIGINAL CONTAINER WITH YOUR DOSAGE INSTRUCTIONS NOTED AND DATED. THIS SECTION MUST BE UPDATED AND SIGNED BY A LHCP WITHIN 12 MONTHS OF ATTENDANCE.

NOTE: If any of the medications listed is indicated as one needed in a crisis, please list and explain the circumstances it should be given in and how to administer it on the line below the original instructions.

<u>MEDICATION</u>	<u>PURPOSE</u>	<u>DOSAGE</u>	<u>MEDICATION TIMES & OTHER INFO</u>
1.			
2.			
3.			
4.			
5.			
6.			

NOTE: Any medications containing salicylates, such as aspirin or Pepto-Bismol, will only be given if the **Licensed Health Care Provider (LHCP)** specifically authorizes its use for the camper.

Camper has permission to be given:

Salicylates Y N LHCP Initials _____

List any medication normally administered to camper that she will **not** be taking during the time she is attending camp.

Participant has parent/ guardian permission to be given:

Tylenol	Y	N	If yes, list dosage: _____
Benadryl	Y	N	If yes, list dosage: _____
Ibuprofen	Y	N	If yes, list dosage: _____
Throat Lozenges	Y	N	If yes, list dosage: _____

Any other over the counter medications (not listed here) will not be administered without contacting the responsible parent or guardian.

CONTINUE ON NEXT PAGE

PART SEVEN: SIGNATURES

PARENT/ GUARDIAN SIGNATURES: PLEASE READ AND SIGN IF YOU ARE THE PARENT OR GUARDIAN OF THE CHILD ON THE FORM.

This health history is correct and complete as far as I know, & the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. 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. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I hereby waive and release the Girl Scouts of Eastern Pennsylvania (GSEP) and all individuals, staff members or volunteers working in connection with camp activities from any and all possible claims for injury to person or property which might arise in connection with my daughter/ward's participation in activities sponsored by or provided by GSEP.

Signature of parent or guardian _____ Date _____

Printed Name _____

I also understand and agree to abide with any restrictions placed on my participation in camp activities.

***IF FOR PERSONAL/RELIGIOUS REASONS YOU CAN NOT SIGN THIS, THEN GSEP SHOULD BE CONTACTED FOR A LEGAL WAIVER WHICH MUST BE SIGNED FOR ATTENDANCE.**

HEALTH CARE EXAM BY LICENSED HEALTH CARE PROVIDER (PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT):

I have examined the above camp applicant and reviewed all information requested by the camp and provided on this form, including all prescriptions and over the counter medications listed.

Date Examined _____

General Physical & Emotional Status _____

In my opinion, the above's condition ___ does ___ does not allow her participation in an active camp program, which may include activities such as swimming, boating, hiking, running, sports, dance, horseback riding, rock climbing, Scuba diving, and/or other physical activities in summer temperatures.

LHCP Restrictions/ Comments _____

Licensed Health Care Provider's Signature _____ Date _____

Licensed Health Care Provider's Name (print) _____

Address _____ Phone _____

TO BE COMPLETED IN CAMP BY HEALTH SUPERVISOR:

Camper Arrival Screening:

Hair/ Scalp	OK	Not OK
Mouth/ Throat	OK	Not OK
Feet	OK	Not OK

Other: _____

Date of Screening _____ Conducted by _____

Comments: _____