girl scouts of eastern iowa and western illinois

2015 HEALTH CARD

BRING THIS CARD WITH YOU TO CAMP

Girl Scouts of Eastern Iowa and Western Illinois

Resident/Day Camp Health History and Examination Form

PLEASE SELECT ONE:

- ○ Girl Camper
- ○ Adult Camper
- ○ Camp Staff

PLEASE NOTE

A complete, signed 2015 Health Card is required for ***all*** participants (girl and adult), regardless of session and program.

The physical examination including physician's signature is now optional for most camp sessions.

Please check your confirmation packet for the list of sessions requiring a physical exam.

Camper Name (Last, First, Initial)	Name & Relationship of parent/guardian completing this form			Daytime Phone ( )		
Address (Number and Street)	City or Town	State	Zip Code	Date of Birth	Age	Grade entering

EMERGENCY CONTACT INFORMATION: Must include parent/guardian or person completing form.

NAME	RELATIONSHIP	DAYTIME PHONE	EVENING PHONE	CELL PHONE

Are there any legal custodian issues we should be aware of? ○ **No** ○ **Yes** **If yes, please explain:** _____

INSURANCE INFORMATION - Is the participant covered by family medical/hospital insurance? ○ **Yes** ○ **No**

If yes, carrier or plan name _____ Carrier phone number _____

Policy Number _____ Group Number_____

Name of insured _____ Relationship to participant _____

Family Doctor and phone number _____

Dentist/Orthodontist and phone number(s)_____

Date of last health examination _____ Were there any medical problems at the time? _____

HEALTH HISTORY – Must be completed by parent/guardian.

Check all that apply and explain any of the checked items, restrictions or other conditions we should be aware of.

CHRONIC OR RECURRING ILLNESS

- ☐ Asthma
- ☐ Bleeding /Clotting Disorders
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Mononucleosis
- ☐ Musculoskeletal Disorders
- ☐ Seizures/Epilepsy
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Other (specify) _____

OTHER HEALTH CONDITIONS

- ☐ ADD/ADHD
- ☐ Bedwetting
- ☐ Behavioral Disturbances
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Emotional Disturbances
- ☐ Fainting
- ☐ Frequent Colds
- ☐ Frequent Headaches
- ☐ Frequent Sore Throats
- ☐ Other (specify) _____
- ☐ Frequent Stomach Aches
- ☐ Hearing Impairment
- ☐ Menstrual cramps
- ☐ Motion Sickness
- ☐ Night Terrors
- ☐ Nosebleeds
- ☐ Pediculosis (Lice)
- ☐ Sleepwalking
- ☐ Wears glasses/contacts
- ☐ Wears orthodontic devices
- ☐ Other (specify) _____

Explanation(s)

In the last year, has the participant had:

- ☐ An injury/illness requiring medical attention
- ☐ A surgical operation or fracture
- ☐ Restrictions from participating in P.E. class
- ☐ An illness lasting longer than 5 days
- ☐ Hospital treatment
- ☐ Exposure to a contagious disease

Is the participant currently:

- ☐ Receiving psychological counseling
- ☐ Under a physician's care
- ☐ Restricted from physical activity
- ☐ Taking prescription medication *(Complete reverse side.)*
- ☐ Taking over-the-counter medication *(Complete reverse side.)*

Please explain any items checked above. Give dates and include any information that would be helpful to camp staff in relation to these health conditions. Add an additional sheet if needed.

ALLERGIES: ☐ No known allergies

This camper is allergic to: ☐ Food ☐ Medicine ☐ the environment (insect stings, hay fever, etc) ☐ other

(Please describe below what the camper is allergic to and the reaction seen.) Do you carry an EpiPen? ___

Diet, Nutrition:

- ☐ This camper eats a regular diet
- ☐ This camper eats a regular vegetarian diet
- ☐ This camper has special food needs. (Please describe below.)

Has camper had:

Chicken Pox	☐ **Yes**	☐ **No**
Measles/German Measles	☐ **Yes**	☐ **No**
Mumps	☐ **Yes**	☐ **No**
Hepatitis	☐ **Yes**	☐ **No**

Campers' first and last name _____

OTHER INFORMATION

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

Has your daughter begun menstruation? ☐ **Yes** ☐ **No**

Specify activities to be encouraged: _____

Specify activities to be restricted: _____

List necessary adaptations or limitations: _____

_____

Height:_____ Weight:_____

General physical and emotional status _____

The following medications are provided at each camp. These products are recommended by our camp physicians through our standing orders. They will be administered under the health supervisor's or designee's supervision; dosage as appropriate for weight and/or age. Please check which medications can be given to your camper.

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofin (Motrin)
- ☐ Decongestant (Sudafed)
- ☐ Antihistamine (Claritin)
- ☐ Antacid (Tums)
- ☐ Antidiarrheals (Pepto-Bismol)
- ☐ Diphenhydramine (Benadryl)
- ☐ Expectorant (cough suppressant, cough drops)
- ☐ Naphazoline/Pheniramine (Visine)
- ☐ Topical Corticosteriod (Hydrocortisone Cream)
- ☐ Antihistamine (Talcum Powder)

RECORD OF IMMUNIZATION

Please list date of last immunization or provide a copy of immunizations or write "All Current." Adult campers need only to list the last date of Tetanus.

Name of immunization	Date of last immunization
MMR (Measles, Mumps, Rubella)	
Polio	
Hib B	
Hepatitis B	
Varicella (Chicken Pox)	
Tetanus (adults)	
DTaP/Tdap (Diphtheria, Tetanus, Pertussis)	
Tuberculin Test year last given	Result

What have we forgotten to ask about your child?

Prescription or over-the-counter medications brought from home MUST be in their original container, clearly labeled, and can only be given according to package directions or as prescribed by a physician. ***(Please complete below)***

MEDICATION	CONDITION TREATED	DOSAGE	TIME OF DAY	TAKEN WITH FOOD?
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other _____	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other _____	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other _____	

Please read each of these statements and sign on the line at the bottom, indicating your agreement.

This health history is complete and accurate so far as I know and the above stated person has my permission to participate in all activities, including strenuous activities such as hiking, swimming, climbing hills, horseback riding (if applicable), and including off-site travel when it is part of the program except as noted by me and the examining physician. I understand that when participating in Girl Scout activities, participants may be photographed for print, video or electronic imaging and that those images may be used in published formats and belong to the Girl Scouts.

I hereby give permission for the camp staff to provide routine health care, administer prescribed and non prescription medication, arrange necessary transportation, seek emergency medical treatment, including X-rays, routine tests, injections and/or anesthesia and/or surgery, for camper named above. I understand all precautions will be taken for camper care and supervision. In case of an emergency, the camp staff will call at least one of the contacts on the list. If none of the contacts on this form 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.

For participants attending a session lasting two nights or more:

Girl Scouts of Eastern Iowa and Western Illinois encourages families to have their camper have a physical examination within 12 months of the end of the camp session. We have chosen not to require the physical examination for most camp sessions due to the expenses incurred to the families and/or additional effort by the parent/guardian to obtain the information from previous examinations. It is the parent/guardian's choice to share the examination results and have a physician sign the form. Those sessions that we will be requiring the physical examination documentation are listed in the confirmation packet.

___ I choose not to share the last physical information and to the best of my knowledge, the camper is and has been in normal good health and is free from all communicable or contagious diseases. By choosing to not share the examination results, I am releasing the camp from responsibility for any impairment of health that might occur as a result of not sharing the results.

I understand the information on this form will be shared on a "need to know" basis with camp staff in order to provide adequate safety and health care to the participant. The completed forms may be photocopied for trips out of camp. I entrust care of my child to camp staff during her visit. Beyond this I will not hold camp staff or the Girl Scouts of Eastern Iowa and Western Illinois responsible or liable.

******PARENT/GUARDIAN SIGNATURE** _____ **DATE** _____

************************************PHYSICAL EXAMINATION************************************

EXAMINATION DATE: ____/____/___

NOTE TO PHYSICIAN: The camper's parent/guardian or adult camper has chosen to share information about the last exam done within 12 months of the end of the camp session or the camper is attending a session that is required to have a physical examination. Please review the completed health history and complete the information pertinent to the camper's physical health and her/his camp session and sign and date below.

I have examined the camp applicant named above.

In my opinion, her/his health **does** ___ **/ does not** ___ allow her/his participation in an active camp program.

Physician's Recommendations and Restrictions at camp:

Additional Health Information camp personnel should be aware of:

Licensed physician's name:

_____

Licensed physician's signature:

_____

Street Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Date _____