GIRL SCOUTS OF NORTHERN CALIFORNIA

CAMPER HEALTH RECORD AND EMERGENCY INFORMATION

This part to be filled in by adult and reviewed with practioner at the time of examination

Name (Last, First, Initial) **Birth Date** **Grade**

Address **City/Town** **State** **Zip** **Phone** ( )

Parent/Guardian's (1) Name **E-Mail Address (For GSNC use only)** **Home Phone** ( )

Place of work **Title** **Work Phone** ( )

Parent/Guardian's (2) Name **E-Mail Address (For GSNC use only)** **Home Phone** ( )

Place of work **Title** **Work Phone** ( )

Name of Alternate Emergency Contact If Parent/Guardian are Unavailable **Relationship** **Home Phone** ( )

Address **City/Town** **State** **Zip** **Work Phone** ( )

INSURANCE INFORMATION, PLEASE COMPLETE THE FOLLOWING:

Carrier **ID Number** **Group Number**

Member Services Phone Number **Address** **City/Town** **State** **Zip**
( )

HEALTH HISTORY: (Check those that apply)

DISEASES:
- ☐ Chicken Pox
- ☐ Measles
- ☐ German Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Kidneys

ALLERGIES:
- ☐ Animals:_____
- ☐ Food: _____
- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Medicine/Drugs:_____
- ☐ Plants:_____
- ☐ Pollen
- ☐ Other(specify): _____
- ☐_____
- ☐_____
- ☐_____
- ☐_____

CHRONIC or RECURRING ILLNESS:
- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Seizures
- ☐ Bleeding Disorders
- ☐ Asthma
- ☐ Hypertension
- ☐ Diabetes
- ☐ Musculoskeletal Disorders
- ☐ Arthritis
- ☐ Sinusitis
- ☐ Other(specify): _____

APPLIANCES:
- ☐ Hearing Aid
- ☐ Orthopedic Braces
- ☐ Glasses
- ☐ Contact Lenses
- ☐ Dental Braces
- ☐ Retainer
- ☐ Other(specify):_____
- ☐_____
- ☐_____
- ☐_____
- ☐_____
- ☐_____

SUGGESTION FROM PARENT/GUARDIAN:
My daughter has permission to take or use the following:
- ☐ Tylenol/Acetaminophen
- ☐ Advil/Ibuprofen
- ☐ Sudafed/decongestant
- ☐ Benadryl/antihistamine
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Robitussin/expectorant
- ☐ Swimmer's Ear/alcohol-vinegar solution
- ☐ Cough drops

DETAILS OF ANY CHECKED ITEMS ABOVE (i.e. allergic reactions to bee stings, food, or medications/drugs) _____

PLEASE DESCRIBE CONDITIONS AND GIVE DATES:

Operations or serious injuries:

Hospitalizations:

List any other diseases or disabilities:

Fainting _____ Sleep Disturbances _____
Bed Wetting _____ Menstrual Cramps _____
Constipation _____ Nosebleeds _____
Emotional Disturbances _____ Other (Specific) _____
Specific Activities to be Encouraged _____ Restricted _____

Any known recent exposure to contagious disease(s) within the last 6 weeks? ☐ YES ☐ NO If YES, give details:

Have you talked to your girl about menstruation? ☐ YES ☐ NO Has she started menstruating? ☐ YES ☐ NO

Is your child currently under care of physician or psychologist? ☐ YES ☐ NO If YES, give details:

Special medical or dietary regimen to be followed (specify):

PARENT CONSENT: This Camper Health Record and Emergency Information is complete and accurate to my knowledge. My daughter has permission to engage in all prescribed activities, except as noted by me and by the examining physician. I give permission for her to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood that every effort will be made to contact me or the person(s) noted above before taking this action.

SIGNATURE OF PARENT/GUARDIAN: **DATE:**

Name: _____ **Date:** _____

This part to be filled in by licensed practitioner after review of health history with parent/guardian

HEALTH EXAMINATION

Height _____ **Weight** _____ **B.P.** _____

Appearance-Nutrition _____

Without Glasses: **Eyes R 20/**_____ **L 20/**_____ | **With Glasses:** **R 20/**_____ **L 20/**_____

Ears _____ **Hearing R** _____ **L** _____

CODE:
Satisfactory=S Not Satisfactory=NS Not Examined=NE

Nose _____ **Throat** _____
Teeth _____ **Heart** _____
Lungs _____ **Abdomen** _____
Genitalia _____ **Hernia** _____
Skin _____ **Musculoskeletal** _____
General physical and emotional status _____
Urinalysis* _____ **HGB*** _____
Other notes _____

Physician's comments and recommendations. Give details or indicate management or significant illnesses.

_____
_____
_____
_____
_____

***Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty.

RECORD OF IMMUNIZATION

Immunization	Year Primary Series Completed	Year of Last Booster
DTaP		
Diphtheria		
Pertussis (Whooping Cough)		
Tetanus (within last 10 years)		
Td		
Oral Polio/IPV		
Measles		
Mumps		
Rubella		
Hib		
Hep B		
Tuberculin Test	**Year last given** _____	**Result** _____
Typhoid and Paratyphoid		
Cholera		
Yellow Fever		
Typhus		
Rocky Mountain Spotted Fever		
Other: (specify)		

This person is in satisfactory condition and may engage in all usual activities except as noted. _____

(Print) Licensed Practioner's Name | **Licensed Practioner's Signature**

Address/City/State/Zip

E-Mail

Area Code + Phone ( ) **FAX: Area Code + Phone** ( ) **Date**

This information is needed to measure how well your council is serving the Bay Area's diverse population, it will be combined with everyone in the troop without identifying anyone individually.

The girl's racial background is: *(please check as many as apply)* ❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American ❒ Hawaiian or Pacific Islander ❒ White ❒ Other*(specify)*_____

The girl's ethnic background is: *(please check one)* ❒ Hispanic or Latino ❒ Not Hispanic or Latino

Is your girl/ward disabled? ❒ NO ❒ YES If YES, does she need accommodation? ❒ NO ❒ YES If YES, attach a separate paper to explain.

MEDICATIONS: The camp cannot administer medication that is not in its original bottle, labeled with the child's own name, accompanied by specific written dispensing instructions by parent/guardian or physician. Medications include, but are not limited to: prescription, over the counter, vitamins, herbal and homeopathic remedies.

IMPORTANT: PLEASE LIST CURRENT MEDICATIONS BEING TAKEN ON SEPARATE PAPER AND ATTACH—INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

HEALTH INFORMATION PRIVACY STATEMENT

The **Camper Health Record and Emergency Information** is for health care concerns at the specified event 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 care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The Camper Health Record and Emergency Information will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

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:** _____