

PARENT: Complete form through Part VII: Parent Consent section on the back.

PHYSICIAN: Complete statement on back of form and date **(within 12 months)**.

TURN IN AT FIRST DAY CHECK IN!

PART I: PARTICIPANT RECORD

Name - Last, First, Middle Initial

Birth Date - MM/DD/YYYY

Age

Home Address

City/State/Zip

Parent/Guardian Name

Day Time Telephone

Evening Phone

Cell Phone

()

()

()

Parent/Guardian Name

Day Time Telephone

Evening Phone

Cell Phone

()

()

()

PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name

Day Time Telephone

Evening Phone

()

()

Home Address

City/State/Zip

Relationship to Girl

PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: _____ Telephone: () _____

Address of family PHYSICIAN: _____ City / State / Zip _____

Family Medical/Hospital INSURANCE CARRIER: _____ POLICY/GROUP NUMBER: _____

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.? Yes No

If yes, what ID number do you use?

What is the HMO main phone number for emergencies? () _____

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction)

Check here for no known allergies

- | | | |
|--|--|--|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Medicines/Drugs _____ |
| <input type="checkbox"/> Pollen _____ | <input type="checkbox"/> Food _____ | <input type="checkbox"/> Insect Stings _____ |
| <input type="checkbox"/> Plants/Poison Oak _____ | <input type="checkbox"/> Other (specify) _____ | |

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Defect/Disease _____ |
| <input type="checkbox"/> Musculoskeletal Disorder _____ | <input type="checkbox"/> Bleeding/Clotting Disorders _____ | <input type="checkbox"/> Ear Infection _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Seizures/Convulsions _____ | <input type="checkbox"/> Mononucleosis _____ |
| <input type="checkbox"/> Skin Disease/MRSA _____ | <input type="checkbox"/> Other (specify) _____ | |

Childhood Diseases: (Check those that apply and give appropriate dates)

- | | | |
|--|--|---|
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> German Measles _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Other (specify) _____ | |

Other Health Conditions: (Check those that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Wears Glasses/Contacts | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Sickle Cell Trait/Disease | <input type="checkbox"/> Special Dietary Regimen | <input type="checkbox"/> Dental Braces | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Autism Spectrum |

List any current physical, mental or psychological health conditions requiring medical treatment, special restrictions or considerations: _____

List any dietary restrictions or special considerations: _____

List any previous medical treatments, operations or serious injuries, provide dates: _____

PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you **DO NOT** want you or your child to receive: _____

Do you take any medications? NO YES

If YES, list medication, dosage, and possible side effects.

MEDICATION	DOSAGE	POSSIBLE SIDE EFFECTS
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_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the name, address, dosage and frequency. Please label with name and dosage any over-the-counter drugs - anti-histamines, vitamins, etc.

PART VI: IMMUNIZATION HISTORY – REQUIRED I am providing a list of all medical immunization with the health history form OR I attest that all immunizations for school are current.

Vaccines	Date: Month / Year	Date: Month /Year
Diphtheria, Tetanus and Pertussis- DTP, DTaP or any combination of DTP or DTaP with DT (tetanus and diphtheria)		
Tdap Booster		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles, Mumps, Rubella (MMR)		
Varicella		
Hepatitis B		
Tuberculin test given		
Other:		

List any condition that would limit full activity and in what way: _____

Additional comments: _____

PART VII: TREATMENT CONSENT

This health history is correct as far as I know, and my daughter has permission to engage in all prescribed activities, except as noted by me and the physician. My daughter is in good health. I give permission for my daughter to receive treatment for routine medical and/or first aid needs, as outlined in the Treatment Protocols and for the administration of prescribed medications. In the event I cannot be reached in an emergency, I give my permission for my daughter (state her name) _____ to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action.

*All medications being taken are listed on the front of this form.

Signature of Parent / Guardian _____ Date _____

PART VIII: RECORD OF HEALTH EXAMINATION

To be completed **WITHIN 12 MONTHS** of camp attendance by a LICENSED PHYSICIAN- MD, PHYSICIAN'S ASSISTANT- PA, OR NURSE PRACTITIONER- NP ACTING UNDER THE SUPERVISION OF A LICENSED MD.

I have examined the above participant within the **past 12 months**. DATE OF EXAM _____

In my opinion, the above participant's condition DOES or DOES NOT preclude her participation in an active program.

Activities to be limited: _____

The participant is under the care of a physician for the following conditions: _____

Current treatment (including medications): _____

Height _____ Weight _____ Blood Pressure _____

Name of MD, PA, or NP: _____

Signature of Physician: _____

Phone: (_____) _____

Date Signed _____

Doctor's Office Stamp or Address



PERSONS AUTHORIZED TO PICK-UP MY CHILD

NAME _____ CAMP _____

SESSION _____ PROGRAM _____ DATE _____

The following persons are authorized to pick-up my child from camp or from the bus unloading. I understand that these people, including myself, will be asked to show identification to the staff member at check out. I understand that if someone who is not on the list attempts to pick up my child, the camp of Girl Scout office will contact me of the emergency contact listed on the front of the health form for authorization. I understand that Girl Scouts of Northern California will not release my daughter to anyone who is not authorized by me as the parent/legal guardian.

Contact phone number: _____

BEFORE CAMP: Please list the authorized pick up people in this section (including parents):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

AT CHECK OUT / TIME OF PICK UP FROM CAMP OR BUS STOP: Leave blank until pick up.

Authorized person sign here at time of pick up only.- PRINT NAME / SIGNATURE