girl scouts of northern california

Staff Health History Record with Physical

TURN IN AT FIRST DAY CHECK IN!

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

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

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**

❒ Animals _____ ❒ Hay Fever _____ ❒ Medicines/Drugs _____
❒ Pollen _____ ❒ Food _____ ❒ Insect Stings _____
❒ Plants/Poison Oak _____ ❒ Other (specify) _____

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

❒ Asthma _____ ❒ Diabetes _____ ❒ Heart Defect/Disease _____
❒ Musculoskeletal Disorder _____ ❒ Bleeding/Clotting Disorders _____ ❒ Ear Infection _____
❒ Hypertension _____ ❒ Seizures/Convulsions _____ ❒ Mononucleosis _____
❒ Skin Disease/MRSA _____ ❒ Other (specify) _____

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

❒ Chicken Pox _____ ❒ Measles _____ ❒ German Measles _____
❒ Mumps _____ ❒ Other (specify) _____

Other Health Conditions: (Check those that apply)

❒Attention Deficit Disorder (ADD)	❒Down's Syndrome	❒Hearing Impairment	❒Nose Bleeds
❒Wears Glasses/Contacts	❒Bed Wetting	❒Emotional Disturbances	❒Menstrual Cramps
❒Sickle Cell Trait/Disease	❒Special Dietary Regimen	❒Dental Braces	❒Fainting
❒Motion Sickness	❒Sleep Disturbances	❒Visual Impairment	❒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

_____

_____

_____

_____

_____

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
Diptheria, 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