Kamp Konocti CIT Training Girl Health History Record

PARENT: *Please complete this form for CIT Training. An additional form that includes MD Physical is required prior to camp.*

Girl's Name - Last, First, Middle Initial **Birth Date** **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 ( )

EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name Primary Telephone ( ) Secondary Phone ( )

HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: _____ **Telephone: (_____)**_____

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

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 _____ ❒ Insect Stings _____ ❒ Other (specify) _____

Chronic or Recurring Illnesses: (Check those that apply and provide any additional information)

❒ Asthma _____ ❒ Diabetes _____ ❒ Heart Defect/Disease _____

❒ Musculoskeletal Disorder_____ ❒ Bleeding/Clotting Disorders_____ ❒ Hypertension_____

❒ Skin Disease/MRSA_____ ❒ Other (specify) _____

Other Health Conditions: (Check those that apply)

❒Attention Deficit Disorder (ADD) ❒Bed Wetting ❒Down's Syndrome ❒Emotional Disturbances ❒Fainting ❒Hearing Impairment

❒Menstrual Cramps ❒Motion Sickness ❒Nose Bleeds ❒Sickle Cell Trait/Disease ❒Sleep Disturbances ❒Wears Glasses/Contacts

Food Allergies:_____ Food Preference ❒Vegetarian ❒ Vegan

MEDICATION

Is your daughter taking any medications? ❒ NO ❒ YES

If YES, list medication, dosage, and reason for taking

MEDICATION DOSAGE REASON

_____

_____

_____

_____

IMMUNIZATIONS

❒ Up to Date

❒ We have chosen not to immunize our daughter

ACTIVITY RESTRICTION ❒ NO ❒ YES

If Yes, list restrictions

_____

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

PARENT CONSENT

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. I understand that in the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Northern California to give emergency medical and surgical treatment and hospitalization as necessary for my child and/or dependent minor by a licensed physician pursuant to Section-6910 of the civil Code of California. I know of no reason(s) other than the information indicated on this form, why my daughter/dependent should not participate in prescribed activities.

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

Parent/Guardian Signature: Date:

PART VIII: HEALTH INFORMATION PRIVACY STATEMENT

The Girl Health History Record 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 health history record 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 history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.***

Parent/Guardian Signature:_____ **Date:** _____

Review Date:_____ Signature: _____

Review Date:_____ Signature: _____