Girl Scouts Heart of Michigan
Camp Health Form - History & Examination

Instructions:

1. The information contained in this health form is used to advise our health care supervisor of each participant's current condition and special needs. It is also the only information we have in case of an accident or emergency. Information on this form is considered confidential and will be shared, as appropriate, only with staff that needs to know.
2. This health form must be completed, signed and brought with you at check-in for your camp session. Campers arriving at camp without a completed form will be sent home with parent(s)/guardian(s).
3. Parent(s)/Guardian(s) should carefully complete sections A, B & C. **Section D MUST be completed by a physician, nurse practitioner or physician's assistant** for girls attending any resident camp program.
4. Parent(s)/Guardian(s) are responsible for making a copy of this form for your records. The original Health History & Examination Form cannot be returned due to State Licensing Requirements (all originals must be kept on file).
5. All health forms from 2011 that have valid health examinations for 2012 will remain on file at camp for use this summer. For a health examination to be valid, it must have been conducted within 24 months of the camp session.
6. A new Health History (sections A-C) must be completed each year.

**If you have any questions regarding whether or not your daughter's health examination is valid for the 2013 camp season, please contact the Camp Director at least two weeks prior to arrival at camp.*

SECTION A – GENERAL PARTICIPANT INFORMATION

Participant Information:

- **Name:**_____ **Phone:**_____
- **Address:**_____
- **SSN:**_____ **DOB:**_____

Parent/Guardian Information:

- She is under the custodial care of:

  ❑ Both Parents ❑ Mother/Guardian only ❑ Father/Guardian only ❑ Other(specify)

- **Parent/Guardian #1 Name:**_____
- **Address:**_____
- **Phone (Day):**_____ **Phone (Evening):**_____ **Phone (Cell):**_____
- **Email:**_____

- **Parent/Guardian #2 Name:**_____
- **Address:**_____
- **Phone (Day):**_____ **Phone (Evening):**_____ **Phone (Cell):**_____
- **Email:**_____

Emergency Contact Information:
In the event that I cannot be reached in an emergency, the following persons will be available during the camp session and are authorized to act in my behalf.

- **Name:**_____
- **Relationship to Participant:**_____
- **Address:**_____
- **Phone (Day):**_____ **Phone (Evening):**_____ **Phone (Cell):**_____

- **Name:**_____
- **Relationship to Participant:**_____
- **Address:**_____
- **Phone (Day):**_____ **Phone (Evening):**_____ **Phone (Cell):**_____

Health Care Information:

- **Physician's Name:**_____
- **Physician's Phone Number:**_____
- **Physician's Address:**_____

- **Dentist's Name:**_____
- **Dentist's Phone Number:**_____
- **Dentist's Address:**_____

- **Insurance Company:**_____ **Policy #:**_____

- **Through (Employer):**_____

- **Insured Name (Parent/Guardian):**_____

SECTION B – GENERAL HEALTH INFORMATION

Immunization History:

	Year Primary Series Completed	Date of Last Booster
***Diphtheria/Pertussis/Tetanus**		
Measles/Mumps/Rubella		
Polio		
Chicken Pox		
***HIB**	1. 2.	3. 4.
Hepatitis B Vaccination	1. 2.	3. 4.
Tuberculin Test (most recent)	Date of Test:	Result:
***Adult Tetanus – Diphtheria Toxoid**		
***Hemophilus Influenza B**		

*Required

- Which of the following, if any, has the participant ever had?

  ❑ Measles ❑ German Measles ❑ Mumps ❑ Chicken Pox ❑ Hepatitis

Medications: *List any prescription medication your camper is bringing to camp, its use and dosage. All medications must be brought in their original containers.*

❑ This person takes NO medications on a routine basis.
❑ This person takes prescription medications as follows.

	Medication #1	Medication #2	Medication #3
Condition			
Dosage			
Frequency			

Allergies: *Please check those that apply, specify what reaction to look for, and the physician-recommended treatment.*

	Penicillin	
	Other Medication	
	Food Allergies	
	Bees/Wasps/Other Insects	
	Plants	
	Animals	
	Asthma	
	Hay Fever	
	Other	

Other Health Conditions: *Please check those that apply.*

	Diabetes		Hearing Impairment		Bed Wetting
	Convulsions/Seizures		Visual Impairment		Constipation
	Heart Defect/Disease History		Emotional/Behavior Disturbance		Abnormal Menstruation
	Rheumatic Fever		Sleep Disturbance		Nosebleeds
	Sickle Cell Trait/Disease		Ear Infections		Motion Sickness
	High Blood Pressure		Urinary Infections		Fainting
	Bleeding/Clotting Disorders		Musculoskeletal Disorders		Sleepwalking
	Frequent Headaches		Recent Injury/Illness/Infectious Disease		Other
	Wears Glasses/Contacts		Eating Disorder		

If a (n) condition has been checked, please provide any pertinent information:

Are there any specific activities that should be restricted, limited, or adapted? ❑ Yes ❑ No

- **If yes, please explain:**

Dietary Restrictions:

☐	Does not eat red meat	☐	Does not eat dairy products
☐	Does not eat poultry	☐	Food Allergies
☐	Does not eat pork	☐	Limited due to orthodontic appliances
☐	Does not eat seafood	☐	Other
☐	Does not eat eggs		

Please provide us with any additional information about the camper's behavior and/or physical, emotional, or mental health that would be important for our health care staff to be aware of to ensure that your daughter has the best experience possible:

Does the camper have an impairment or disability that will require special accommodation while at camp?

❑ Yes ❑ No

If yes, please explain and contact the Camp Director immediately:

SECTION C – CONSENT AND PERMISSION TO TREAT

This health history is correct and complete so far as I know. My child has permission to engage in all prescribed camp activities except where noted. Authorization to treat: I hereby give my permission to the health care staff selected by the camp to order emergency and routine tests including x-rays, emergency treatment and necessary-related transportation for me or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person herein described. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give authorization for the doctors and hospital to release medical information to GSHOM.

If for religious reasons you cannot sign this form, the camp should be contacted for a legal waiver that must be signed for attendance.

Signature of parent/guardian: _____

SECTION D – HEALTH EXAMINATION

This section must be completed by licensed physician, nurse practitioner or physician's assistant within 24 months of the camp session for girls attending any resident camp program.

Physical Examination

Date of Examination: _____

Height _____ Weight _____ Blood Pressure _____

General physical and emotional status: _____

_____

_____

Code: ✓ = Satisfactory **X** = Not Satisfactory **0** = Not Examined

____ Eyes	____ Teeth	____ Lungs	____ Ears
____ Heart	____ Abdomen	____ Nose	____ Throat
____ Musculoskeletal	____ Skin	____ Hernia	____ Genitalia

* Not required for every health exam. Girls aged 5-12 should have it if she has not already had it. Girls aged 13-18 should have this test if she has not had it.

Health Recommendations While at Camp:

In your opinion, the above conditions ❑ *do/* ❑ *do not* preclude participation in an active camp program.

Comments:

Activities to be encouraged or restricted while at camp (dieting, swimming, horseback riding, etc.):

Please describe any treatment to be continued while at camp:

Please list any medications to be continued while at camp:

Medication	Use	Dosage/Frequency

PHYSICIAN'S SIGNATURE:

Physician's Signature_____ Date _____

Print Physician's Name _____ Phone # _____