



CAMPER HEALTH HISTORY FORM

Is your camper attending more than one camp session?
 No. Yes. If yes, only submit this form **one** time.

To be completed by parent/caregiver. Submit this form to the Council at least two weeks prior to session start date by **fax: 757-547-1872, ATT: Customer Care; deliver in-person or mail: GSCCC, 912 Cedar Rd, Chesapeake, VA 23322; OR Peninsula Service Center, 894 J Clyde Morris Blvd, Newport News, VA 23601.**

Dates camper will attend program: from _____ to _____
Month/Day/Year Month/Day/Year
from _____ to _____
Month/Day/Year Month/Day/Year
from _____ to _____
Month/Day/Year Month/Day/Year
Camper's Name: _____
First Middle Last
Birth Date: _____
Month/Day/Year

Camper Home Address: _____
Street Address City State Zip Code

Caregiver with legal custody to be contacted in case of illness or injury:

Full Name: _____ Relationship to Camper: _____
Preferred Phones: (_____) _____ (_____) _____ Email: _____
Home Address: _____
(If different from above) Street Address City State Zip Code

Second caregiver or other emergency contact:

Full Name: _____ Relationship to Camper: _____
Preferred Phones: (_____) _____ (_____) _____ Email: _____

Additional contact in event caregivers cannot be reached:

Full Name: _____ Relationship to Camper: _____
Preferred Phones: (_____) _____ (_____) _____ Email: _____

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet. This camper is lactose intolerant. This camper is gluten intolerant.
 Other *(Describe below.)*

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. **(Describe below.)**

Medical Insurance Information: This camper is covered by family medical/hospital insurance. Yes No

Insurance Company _____ Policy Number _____
Subscriber _____ Insurance Company Phone (_____) _____

Participant Authorization for Healthcare and Release of Liability:

This Health History is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests and treatments related to the health of my child for both routine healthcare and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I further give my permission to the camp administration to select physicians or staff to provide routine care for my child, including dispensing medications and providing first aid. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of the participant's health record from providers who treat the participant and these providers may talk with the program's staff about the participant's health status. The undersigned further agrees to defend, indemnify and hold the Girl Scout Council of Colonial Coast and its agents, servants, officers, directors and employees from any and all claims of every kind or nature and from all suits, actions or proceedings which may be asserted or brought by representatives, successors and assigns of the parties hereto. I have read this form (or have had it read to me) and I certify that I understand its contents. The camper may participate in out-of-camp travel when it is part of the camp program.

Participant* Signature _____ Relationship to Camper: _____ Date: _____

***If participant is under 18 years of age, a caregiver must sign for child's participation in camp activities.**

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Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA Standard. Copies of immunization forms from healthcare providers or state or local government are acceptable; attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: _____ Negative Positive

If the camper has not been fully immunized, please sign the following statement: I understand and accept the risks to the participant from not being fully immunized.

Caregiver Signature: _____ Relationship to Camper: _____ Date: _____

Medication: This camper will not take any daily medications while attending camp.
 This camper will take the following daily medication(s) while at camp.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. **If the participant needs to take any medication at camp, provide the following information below. All medication (both over-the-counter and prescription) must be in its original container with original pharmacy label or manufacturer's label. Medication will not be administered unless accompanied by this form. Provide enough medication for the duration of the camp program. Attach additional sheets if necessary.**

Name of medication	Date started	Reason for taking it	Time it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

CAMPER HEALTH HISTORY FORM

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

The following non-prescription medications are commonly stocked in camp health centers and are used on an as needed basis to manage illness and injury. **Check all items the participant is allowed to be given.**

- Acetaminophen (Tylenol)
- Aloe
- Bismuth subsalicylate (Pepto-Bismol)
- Calamine lotion
- Chloraseptic (Sore throat spray)
- Chlorpheniramine maleate (Chlorphen antihistamine)
- Dextromethorphan (Cough medicine)
- Diphenhydramine (Benadryl)
- Generic cough drops
- Guaifenesin (Cough & cold medicine)
- Hydrocortisone 1% cream
- Ibuprofen (Advil, Motrin)
- Laxatives for constipation (Ex-Lax)
- Lice shampoo or scabies cream (Nix or Elimite)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Topical antibiotic cream

General Health History: Check "Yes" or "No" for each statement.

Has/does the camper:

- | | |
|--|---|
| 1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear?... <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |

Explain "Yes" answers in the space below and indicate the question number. For travel outside the country, name countries visited and dates of travel.

Select her swimming ability: Beginner Intermediate Advanced

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
4. Had a significant life event that continues to affect the camper's life?..... Yes No
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Explain "Yes" answers in the space below and indicate the question number. The camp may contact you for additional information.

Healthcare Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? Provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**