girl scouts of the colonial coast

CAMPER HEALTH HISTORY FORM

To be completed by caregiver. Submit this form to the Council **by May 15th** 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.

Camper's Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Check all dates that apply and only submit this form once **by May 15th**.

	Date	Location	Title
☐	June 16-21	Darden	Adventure Quest; Buddies, Bits & Bridles; Softball Camp; or Counselor in Training I & II
☐	Jun 23-28	Darden	Cooking Up A Storm; Buddies, Bits & Bridles; Softball Camp; or Counselor in Training I & II
☐	Jun 24-28	Norfolk	Camp Fury Norfolk
☐	Jun 30-July 3	Darden	X Marks the Spot or Buddies, Bits & Bridles
☐	July 7-12	Skimino	STEAM Through History, Leader in Action (LiA), or Counselor in Training I & II
☐	July 14-19	Skimino	Let's Get Cooking, Counselor in Training I & II, or Program Aide
☐	July 21-26	Skimino	Challenge Seekers, Leader in Action (LiA), or Program Aide
☐	July 21-26	Skimino	Camp Fury Hampton
☐	July 29-Aug. 2	Apasus	Wizards of Camp Apasus or Program Aide
☐	July 29-Aug. 2	Outback	Wizards of Camp Outback or Program Aide
☐	Aug. 5-9	Apasus	Girl Scouts Go Green or Program Aide
☐	Aug. 5-9	Outback	Girl Scouts Go Green or Program Aide
☐	Aug. 12-16	Outback	Art in the Outdoors or Program Aide
☐	Aug. 12-16	Outback	Camp Fury Chesapeake
☐	Aug. 19-23	Outback	Little Bit of Everything or Program Aide

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 or write "up-to-date" and initial. Copies of immunization forms from healthcare providers or state or local government may be attached 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
Diptheria, 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) ☐ 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 only.** 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
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:________		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:________		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:________		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:________		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:________		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:________		

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First Middle Last

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