



Girl Scouts of West Central Florida

GIRL SCOUTS OF WEST CENTRAL FLORIDA, INC.
PO BOX 18066, TAMPA, FL 33609-18066
CAMPER INFORMATION, HEALTH HISTORY AND EXAMINATION FORM

This form must be completed and returned to the above address at least two weeks prior to camp attendance. (A separate form is needed for each camp attended.) Make a copy and bring with you to camp.

Camp attending ___ Scoutcrest ___ Dorothy Thomas ___ Wildwood ___ Traveling Camp

Date of attendance _____ Session Name _____ Session Number _____

The information on this form is not part of the camper or staff acceptance process. It is used to assist us in identifying appropriate care. Camper Information form (first page) MUST BE NOTARIZED. Health History form (next two pages) must be filled out by parent/guardian of minors or by adults themselves and the Health Exam form (last page) must be completed by approved licensed medical personnel at least every two years and must be updated annually.

Camper Name _____ Birth date _____ Age on arrival at camp _____
Last First Middle

Camper Home Address _____
Street address City State Zip Code

Custodial Parent/Guardian _____ Phone _____

Home Address _____ Cell Phone _____
(If different from above) Street address City State Zip Code

Second Parent/Guardian or emergency contact _____ Phone _____

Home Address _____ Cell Phone _____
Street address City State Zip Code

Emergency contact _____ Phone _____ Cell Phone _____

THIS SECTION MUST BE NOTARIZED

MEDICAL RELEASE

Please indicate any over the counter medications to which your child has had an allergic reaction or you wish us to not give her. _____

I give permission for my child to receive basic treatment from the Health Supervisor. In the event an emergency should arise, whereby my child _____ should need medical attention or hospitalization, permission is granted to a representative of Girl Scouts of West Central Florida, Inc., to grant authorization for necessary care. I understand that every effort will be made to contact me. In the event my child becomes ill and cannot continue with the group or cannot adapt to life at camp, I as parent/guardian do assume full responsibility for all costs involved in returning my child home. I understand that an adult counselor will remain with my child until necessary arrangements with the parent/guardian have been made.

Date _____ Parent/Guardian Signature _____

NOTARIZATION: STATE OF FLORIDA, COUNTY OF _____

Sworn to and subscribed before me this _____ Day of _____, 2006

(Signature of NOTARY PUBLIC, State of Florida)

My Commission Expires: _____

Personally Known (____) OR

Produced Identification (____)

Type of ID _____

(Print, type or stamp Commissioned Name of Notary Public)

This NOTARIZED statement is needed to assure prompt medical attention in the event of an emergency. A camper must have this section notarized by a parent/guardian or a signed religious waiver to remain in camp. (A religious waiver can be requested from council.)

Year

Unit

Name

Camper Health History: The following information must be filled in by the parent/guardian, or adult camper/staff member. The intent of the information is to provide camp health personnel the background to provide appropriate care. Any changes in this form should be provided to camp health personnel upon arrival in camp. Provide complete information so that the camp can be aware of your needs. Keep a copy of the completed form for your records.

Immunization History: Provide the month and year for each immunization. Asterisked (*) immunizations must be current. Copies of immunization forms from healthcare providers or state or local government are acceptable; please 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)	<input type="checkbox"/> Had Measles or Mumps Date: _____						
Polio* (IPV)							
Haemophilus influenza type B (HIB)							
Pneumococcal (PCV)							
Hepatitis B	<input type="checkbox"/> Had Hepatitis B Date: _____						
Hepatitis A	<input type="checkbox"/> Had Hepatitis A Date: _____						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)							
Tuberculosis (TB) test	Date _____	<input type="checkbox"/> Negative		<input type="checkbox"/> Positive			

If your camper has not been fully immunized, please sign the following statement:

I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian _____

Date _____

Relationship to Camper _____

ALLERGIES No known allergies.

Medication allergies (List all known) Describe reaction and management of the reaction.

Food Allergies

Other allergies - include insect stings, hay fever, asthma, animal dander, etc.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire stay at camp. Keep medication in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

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

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Attach additional pages for more medications. Identify any medication taken during the school year that the camper does/may not take during the summer:

General Questions (explain "yes" answers below.)

Has/does the participant:	YES	NO	YES	NO
1. Had any recent injury, illness, or infectious disease?	___	___		
2. Have a chronic or recurring illness/condition?	___	___		
3. Ever been hospitalized?	___	___		
4. Ever had surgery?	___	___		
5. Have frequent headaches?	___	___		
6. Ever had a head injury?	___	___		
7. Ever been knocked unconscious?	___	___		
8. Wear glasses, contacts, or protective eye wear?	___	___		
9. Ever had frequent ear infections?	___	___		
10. Ever passed out during or after exercise?	___	___		
11. Ever been dizzy during or after exercise?	___	___		
12. Ever had seizures?	___	___		
13. Ever had chest pain during or after exercise?	___	___		
14. Ever had high blood pressure?	___	___		
15. Ever been diagnosed with a heart murmur?	___	___		
16. Ever had back problems?	___	___		
17. Been diagnosed with ADD or ADHD	___	___		
18. Ever had problems with joints (e.g., knees, ankles)?			___	___
19. Is an orthodontic appliance being brought to camp?			___	___
20. Have any skin problems (e.g., itching, rash, acne)?			___	___
21. Have diabetes?			___	___
22. Have asthma?			___	___
23. Had mononucleosis in the past 12 months?			___	___
24. Had problems with diarrhea/constipation?			___	___
25. Have problems with sleepwalking?			___	___
26. Have an abnormal menstrual history?			___	___
27. Have a history of bed-wetting?			___	___
28. Ever had an eating disorder?			___	___
29. Ever had emotional difficulties for which professional help was sought?			___	___

Please explain any "yes" answers, noting the number of the questions.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

RESTRICTIONS

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary) _____

Dietary

(These are dietary preferences not allergies, see previous page for allergies.)

___ Does not eat eggs	___ Does not eat poultry	___ Does not eat red meat
___ Does not eat dairy products	___ Does not eat seafood	___ Does not eat pork
___ Lactose intolerant	___ Prefers vegetarian diet	Other (describe) _____

IMPORTANT—THIS BOX MUST BE COMPLETE FOR ATTENDANCE

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.
 I hereby give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the camp to provide routine health care, administer prescribed medications and any needed over the counter medications (except as noted), and seek emergency medical treatment, including ordering x-rays and routine medical tests. I agree to the release of any records necessary for insurance purposes.
 I give permission to the camp to arrange necessary transportation for my child.
 In the event 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 named above.

Signature of parent/guardian or adult camper/staff _____ Date _____ Relationship to camper _____
 Printed Name _____ Date _____

Insurance Information

Is the camper covered by family medical/hospital insurance? _____ Yes _____ No

Please attach a photocopy of front and back of health insurance card and be sure information is readable.

If so, indicate carrier or plan name _____ Group # _____

Subscriber _____ Insurance company phone number _____

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (Must be within the last 24 months of camp attendance.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant _____ is _____ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

Medications to be administered at camp (name, dosage, frequency):

Any medically-prescribed meal plan or dietary restrictions:

Known allergies:

Description of any limitations or restriction on camp activities:

Additional information for health care staff at the camp:

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

Screening Record

CAMP USE ONLY

Date screened _____ Updates/additions to health history noted _____ Yes _____ No

Medications received _____

Current health needs identified _____

Temperature _____ Foot Check _____ Head Check _____ Ear Drops _____ Yes _____ No

Screened by _____