girl scouts of west central florida

Health History and Medical Examination Form

Camper Name: ____ **Date of Birth:** ____________________

A medical examination is required for overnight camps and must be completed and signed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 12 months (other physical/examination forms are excepted if exam was completed in the preceding 12 months and signed by the physician). Please call us if you have any questions.

Medical Examination – Must be completed in detail.

Height:	Weight:
Eyes: With Glasses R 20/	L 20/
Eyes: With Glasses R 20/	L 20/

B. P.:	
Hearing:	R L

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

	Nose		Abdomen		Appearance/Nutrition
	Throat		Hernia		General Physical State
	Teeth		Genitalia		General Emotional State
	Heart		Skin		Other:
	Lungs		Musculoskeletal		

Record of Immunization – Must be completed in detail:

Required Immunizations		
	Date Series Was Completed	Year of Last Booster
Hep B		
DTap/Tdap		
Hib		
IPV/OPV		
PCV7		
MMR		
Varicella		
Other:		

Recommended but not Required Immunizations		
	Date Series Was Completed	Year of Last Booster
HPV		
Rota		
MCV4/MPSV4		
Hep A		
TIV/LAIV		
COVID		
Other		

Personal and religious beliefs dictate against immunizations: Yes No

Allergies:

- ☐ Animals
- ☐ Food
- ☐ History of anaphylaxis
- ☐ Medications
- ☐ Seasonal
- ☐ Takes allergy medication
- ☐ Other: _______________

Special Dietary Needs:

- ☐ Egg allergy
- ☐ Gluten intolerant/celiac
- ☐ Lactose intolerant
- ☐ Peanut/ tree nut allergy
- ☐ Vegetarian
- ☐ Vegan
- ☐ Other: _______________

Medical Conditions:

- ☐ Asthma
- ☐ Bed Wetting
- ☐ Behavioral/ mental health concerns
- ☐ Bleeding/clotting disorders
- ☐ Diabetes
- ☐ Hearing impairment
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Fainting
- ☐ Learning/cognitive delay
- ☐ Musculoskeletal disorders
- ☐ Prior hospitalization
- ☐ Prior serious injury
- ☐ Prior surgery
- ☐ Seizures
- ☐ Sleep disturbances
- ☐ Speech impairment
- ☐ Visual impairment
- ☐ Other: ______________

Please elaborate on any positive responses. Attach addendum if necessary:

____

____

____

Asthma / Albuterol Inhaler

☐ Camper does not have asthma and does not use an albuterol inhaler

☐ Camper uses an albuterol inhaler

For camper safety, albuterol inhalers are recommended to be stored with the Camp Nurse unless the camper has a history of severe or rapidly progressing asthma symptoms requiring immediate access.

Please check all that apply:

☐ Albuterol inhaler will be kept with the Camp Nurse

☐ Camper has severe asthma symptoms and requires immediate access to the inhaler

☐ Camper is able to self-administer the albuterol inhaler

☐ Camper is authorized to carry the albuterol inhaler at camp

Known triggers: ____

Typical symptoms / warning signs: ________________________

Additional instructions: ______________________________

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Severe Allergies / Epinephrine Auto-Injector (Epi-Pen)

☐ Camper does not have a severe allergy and does not require an epinephrine auto-injector

☐ Camper requires an epinephrine auto-injector (Epi-Pen or equivalent)

For camper safety, epinephrine auto-injectors are recommended to be stored with the Camp Nurse unless the camper has a history of severe or rapidly progressing allergic reactions requiring immediate administration.

Please check all that apply:

☐ Epinephrine auto-injector will be kept with the Camp Nurse

☐ Camper has severe allergy symptoms requiring immediate access

☐ Camper is able to self-administer the epinephrine auto-injector

☐ Camper is authorized to carry the epinephrine auto-injector at camp

Allergen(s): ____

Typical reaction symptoms: ________________________________

Additional instructions: __________________________________

Provider Clearance

This camper is medically cleared for overnight camp (please circle one): Yes No

Physician Information

<table>
<tr><td colspan="3">Licensed Physician Name: (Last, First, Middle Initial)</td><td colspan="3">Phone Number:</td></tr>
<tr><td colspan="3">Address:</td><td>City:</td><td>St:</td><td>Zip:</td></tr>
<tr><td colspan="6">This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.</td></tr>
</table>

Signature of Licensed Physician:____

State License Number:______________________________**Date:** ________________