

GIRL SCOUTS HEART of the HUDSON - DAY CAMP GIRL HEALTH RECORD

Name (Last, First, Initial)		Parent or Guardian			
Address			City	State	Zip
Mom's Home () _____	Dad's Home () _____	Date of Birth		Age	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Mom's Cell () _____	Mom's Work () _____				
Dad's Cell () _____	Dad's Work () _____				
Emergency Contact Person & Relationship to Camper (Not yourself, we always try parents/guardian first!)		Home Phone () _____			
		Cell Phone () _____			
		Work Phone () _____			
Child's Physician: _____					
Phone: () _____					

Rocky Brook

Birch Ridge

Addisone Bovce

Sian Here

Allergies: No Known Allergies

To foods (list):

To medications (list):

To the environment (insect stings, hay fever, etc. – list):

Other allergies (list):

Describe previous reactions:

Diet, Nutrition: Eats a regular diet. This camper eats a regular vegetarian diet.

This camper has special food needs. **(Please 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. **(Please describe below.)**

Is the participant covered by family medical/hospital/prescription insurance? 0 Yes 0 No

Photocopy of front and back of all health insurance cards must be attached to this form.

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has my permission to engage in all prescribed camp activities, except as noted by me and/or a physician. I give permission to the physician selected by the camp and/or his designated associates to order x-rays, routine tests, and treatment related to the health of my child for both routine health care 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 understand the information on this form will be shared on a "need to know" basis with camp staff. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian _____ Date _____

Office Use Only

Office Use Only	
Insurance	
Parent Signature	
Med HX 6 th months	
Camper Confidential	
Immuno HX	

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

Has/does the camper:

- 1. Ever been hospitalized? Date:_____ Yes No
- 2. Ever had surgery? Date:_____ Yes No
- 3. Have recurrent/chronic illnesses? Yes No
- 4. Had a recent infectious disease? Date:_____ Disease:_____ Yes No
- 5. Had a recent injury? Date:_____ Injury:_____ Yes No
- 6. Had asthma/wheezing/shortness of breath? Yes No
- 7. Have diabetes? Yes No
- 8. Had seizures? Last seizure:_____ Yes No
- 9. Had headaches or migraines? Yes No
- 10. Wear glasses, contacts, or protective eyewear? If so, what type? _____ Yes No
- 11. Wear hearing aids or have hearing problems? Yes No
- 12. Had fainting or dizziness? Yes No
- 13. Passed out/had chest pain during exercise? Yes No
- 14. Had mononucleosis ("mono") during the past 12 months? Date:_____ Yes No
- 15. Have problems with periods/menstruation? Yes No
- 16. Have a problem with falling asleep/sleep walking? Yes No
- 17. Ever had back/joint problems? If so, what joint?_____ Yes No
- 18. Have a history of bedwetting? Yes No
- 19. Have problems with diarrhea/constipation? Yes No
- 20. Have any skin problems? If so, what type? _____ Yes No
- 21. Traveled outside the country in the past 9 months? Date and place: _____ Yes No

If you would like to provide any additional information regarding the above responses, please use the space provided below.

Please list any or all medications being taken including name, dosage, and time usually taken:

1 _____
2 _____
3 _____

If any medication needs to be dispensed at camp, the enclosed medication sheet must be filled out and signed by both a parent and a physician.

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

Has the camper:

- A. Ever been diagnosed with Attention Deficit Disorder? Yes No
- B. Ever been diagnosed with Attention Deficit Hyperactivity Disorder? Yes No
- C. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
- D. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
- E. 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.)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

GIRL SCOUTS HEART OF THE HUDSON, INC.
CAMPER CONFIDENTIAL TO BE FILLED OUT BY PARENT OR GUARDIAN

Two copies of this page are required; one is kept with the medical records and one given to the Unit Staff.

CAMPER'S FULL NAME: _____
Last First Middle

GRADE IN FALL: _____ CAMP PROGRAM: _____

We earnestly desire to have our camp offer your child the happiest, most beneficial experience possible. Please answer the following questions regarding your child's interests and abilities.

1. Does your camper have any allergies (food, medication, insects, etc.)? _____
2. Does your child have asthma? _____
3. Does your camper have any food restrictions? _____
4. What is your child's eating habits? _____
5. Does your child have any fears? _____
6. No. of brothers _____ Ages _____ No. of sisters _____ Ages _____
7. What is your child's physical activity level? High _____ Medium _____ Low _____
8. Is your child easily frustrated? _____
9. How does your child express emotions? _____
10. What does sad look like? Frustrated? Mad? _____
11. How does your child respond to change? _____
12. Is your child sensitive to sight, sound or touch? _____
13. Would you characterize your child as flexible? _____
14. Is your child easily distracted? _____
15. What are your child's special abilities? _____
16. What are your child's hobbies? _____
17. Does your child wet the bed? _____

Please repeat on this page any items from your camper's health history that her councilors should be aware of. Be sure to include asthma, allergies, seizure disorders, medications, learning disabilities, behavioral patterns, emotional sensitivities, restricted mobility and any other pertinent information.

In what way did previous camp experience benefit your child? _____

What do you hope your child gains from her camp experiences this year? _____

Has any recent event affected your child in a way that might make her unhappy away from home? (such as death of a pet, parent away on long trip, impending or recent move, separation of parents, etc.) _____

Additional Comments: _____

Relationship to camper: _____ Signature _____

Immunization History: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable: please return with 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)						xxxxxxxxxx
Tetanus booster* (dT) or (Tdap)	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	
Mumps, measles, rubella (MMR)			xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	
Polio (IPV)					xxxxxxxxxx	xxxxxxxxxx
Haemophilus influenzae type B (HIB)					xxxxxxxxxx	xxxxxxxxxx
Pneumococcal (PCV)					xxxxxxxxxx	xxxxxxxxxx
Hepatitis B				xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Hepatitis A			xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Varicella (chicken pox)	<input type="checkbox"/> Had disease Date:		xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
Meningococcal meningitis		xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx

*A Tetanus shot given within 10 years is required.

Tuberculosis (TB) test	Date:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
------------------------	-------	-----------------------------------	-----------------------------------

Girl Scout Camp Asthma Form

Name: _____ Date of Birth: _____

About Triggers

What triggers your asthma? Provide details about the triggers, including things the staff should be told.

- Exercise _____
- Fatigue _____
- Dehydration _____
- Stress _____
- Food Item _____
- Smoke _____
- Respiratory infections/Common cold _____
- Allergen _____
- Other _____

Using a Peak Flow Meter

We recommend using a peak flow meter as a way to monitor your asthma and note signs of a potential flare before it is well established. **Please bring your peak flow meter to camp.**

When do you take peak flow readings?

- Breakfast Lunch Supper Bedtime Other _____

Routine peak flow reading (green zone) _____

Caution range (yellow zone) _____

What is done if the peak flow reading drops to the caution/yellow range? _____

Danger range (red zone) _____

What is done if peak flow reading drops to the danger/red zone? _____

Nebulizer Treatment and Use

Will you bring a nebulizer to camp? Yes No

If yes, do you know when you need you nebulizer? Yes No

What medication is used via nebulizer? _____

Administration of Medication

The administration of the medications may be supervised by the Camp Director or Unit Leader if the Health Supervisor is unavailable: Yes No

About Medications

These medications are used daily to manage asthma.

Medication Name	Dose Given	When	Reason for Using this Medication

These medications are taken "as needed" to prevent an asthma flare.

Medication Name	Dose Given	When	Reason for Using this Medication

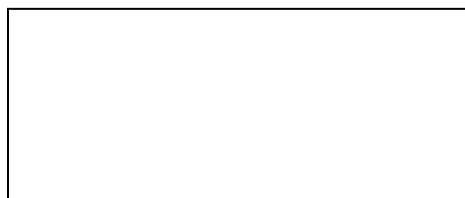
These medications are used when asthma flares.

Medication Name	Dose Given	When	Reason for Using this Medication

Emergency medications must be portable! Nebulizers that require electricity are not practical for many camp trips. Call the Camp Health Director if you have any questions.

Signed: _____ Date: _____
 (Parent / Guardian)

Signed: _____ Date: _____
 (Physician)



Physician's Stamp

THIS FORM MAY BE SUBSTITUTED FOR THE MEDICATION FORM FOR ASTHMA MEDICATIONS. A Medication Form must be completed for all medications a camper needs to be given (including vitamins, salves, ointments, drops, etc.)



Girl Scouts Heart of the Hudson, Inc.
www.girlscoutshh.org

GIRL SCOUT SUMMER CAMP MEDICATION FORM

Name: _____ Date of Birth: _____

THIS FORM MUST INCLUDE ALL MEDICATIONS (over the counter and prescriptions) A CAMPER NEEDS TO BE GIVEN (including vitamins, salves, ointments, drops, etc.). The form and medication will be collected by the Camp Health Supervisor. Campers are NOT allowed to keep any medication in units. Any medication brought to camp WILL NOT be given unless this form has been COMPLETED.

This form must be signed by both the parent/guardian and a physician. A physician must sign this form even if your child is only taking over the counter medications!

MEDICATION NAME, DOSAGE & ROUTE	WHEN TAKEN (SPECIFIC TIMES)	FOR WHAT PURPOSE

The administration of this medication may be supervised by the Camp Director or Unit Leader if the Health Supervisor is unavailable: Yes () No ()

Date

Parent's or Guardian's Signature

Date

Physician's Signature

Stamp