



Health History Form

Complete one for each youth and adult camper.

Camper's Name _____ Birthday _____
Address _____ City _____ State _____ Zip _____

Emergency Information: Custodial Parents/Guardians Names _____

Home Phone _____ Cell Phone _____

Emergency contact (if parent/guardian cannot be reached)

Name _____ Relationship to Camper _____

Home Phone _____ Cell Phone _____

Others authorized to pick camper up: _____ **Relationship** _____

Camper's Physician _____ Office Phone _____

Insurance Carrier _____ Policy # _____ Group # _____

If hospitalization is required, take camper to _____

| Allergies: Check those that apply, specify nature and if treatment requires the use of Epipen, Benadryl, etc.) | | | |
|--|--|---|--|
| Allergy | Nature of Allergy/ Treatment | Allergy | Nature of Allergy/ Treatment |
| <input type="checkbox"/> None | | <input type="checkbox"/> Hay Fever | |
| <input type="checkbox"/> Animals | | <input type="checkbox"/> Medicine/Drug | |
| <input type="checkbox"/> Food | | <input type="checkbox"/> Plants | |
| <input type="checkbox"/> Insect Sting | | <input type="checkbox"/> Other | |
| Illnesses, injuries or Health conditions: (check all that apply) | | | |
| <input type="checkbox"/> None | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Head Aches | <input type="checkbox"/> Motion sickness |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Heart disease/defect | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Other: |
| Immunizations | | | |
| <input type="checkbox"/> Immunizations are up to date | | | |
| <input type="checkbox"/> Family chooses not to immunize | | | |
| Date of last Tetanus shot: _____ | | | |
| Health Supervisor Permission for Medications: (check all that apply) | | | |
| Camper may take acetaminophen (ex. Tylenol) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Camper may take oral antihistamine (ex. Benadryl) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Camper may take ibuprophen (ex. Advil) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Camper may use topical antihistamine (ex. Benadryl) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Camper may use antibiotic ointment (ex. Neosporin) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Camper may use topical hydrocortisone (ex. Cortizone) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you checked yes to any illnesses, injuries or other health conditions, please attach a separate sheet of paper with explanation. Give nature, dates, period of any disability and results. Also, list any activities that should be restricted.

Information about medications:

Is camper taking any medications? YES NO

If yes, attach a list of the camper's current medications to this form; send a list of any medication changes or updates the first day of camp.

- Medications for campers under the age of 18 must be kept in the possession of the health supervisor at all times (unless otherwise noted)
- Any medication to be dispensed should be indicated on the Health History Form.
- All medication, including over-the-counter products, should be in the original container and marked clearly with the participant's name and directions for use.
- Prescribed medications and over-the-counter products must be administered in the prescribed dosage by or in the presence of the health supervisor or as per the written instructions of a custodial parent, a guardian, or a physician.
- Medication can only be dispensed to the person named on the prescription container.
- As per the Safety-Wise chapter of Volunteer Essentials, medications, including over-the-counter products, cannot be dispensed **without prior written permission from a girl's custodial parents or guardian.**

HEALTH INFORMATION PRIVACY STATEMENT FROM GSUSA

The Health History Form is for the health care concerns at this camp only. All medical records will be held in limited access by the health care supervisor of this camp. Minimal necessary information may be shared with camp staff/volunteers in order to provide adequate participate safety and health care. The health history form will be retained by GSEWNI along with all forms/records with noted treatment for seven year past the age of maturity of the participant. Access to the information will be limited. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Parents or Guardian's Statement & signature- My camper has had a physical examination within the past 24 months and is in good health. I give full permission for my camper to attend camp and participate in all activities (except as noted on this health history.) The Girl Scouts of Eastern Washington and Northern Idaho is held harmless in the event of an accident. In the case of injuries, I give permission for medical treatment as deemed necessary. I agree that all information including immunizations is complete and up to date.

Volunteer Statement & Signature- I am in good health and able to participate in all activities at camp (except as noted on this health history.) The Girls Scouts of Eastern Washington and Northern Idaho is held harmless in the event of an accident. In the case of an injury, I give permission for medical treatment as deemed necessary.

Permission is granted to use any picture or video footage of my camper for Girl Scout promotional purposes.

Parent/Guardian or Volunteer Signature _____ Date _____