girl scouts of connecticut

In accordance with the provisions of 105 CMR 430.000 Minimum Sanitation and Safe Standards for Recreational Camps for Children, Massachusetts State Sanitary Code, Chapter IV.

CAMP NAME: _____

SESSION DATES: _____

GIRL SCOUTS OF CONNECTICUT

www.gsofct.org 1-800-922-2770

CAMPER/STAFF HEALTH RECORD - HEALTH HISTORY

- To be completed by parent/guardian or staff member, as applicable.
- This form should provide current information for summer camp.
- Please make a copy of this form for your records prior to sending it to GSOFCT. GSOFCT maintains forms as required by law, but requires new submission of form annually.

Mail completed health record to:
Outdoor Program Department
Girl Scouts of Connecticut
20 Washington Avenue
North Haven, CT 06473

Participant Information

Name (Last, First, Initial)	Parent/Guardian (Primary Contact)	Birth date	Age at Camp

Address	City	ST	Zip

Home Phone	Work Phone	Cell Phone

In Emergency Notify(Secondary Contact)	Relationship to Girl	Cell Phone	Home Phone	Work Phone

Insurance Information (List your primary policy. This information may be released, if necessary, for insurance purposes.)

Carrier	ID Number	Group Number

Member Services Phone Number	Address	*I accept full responsibility for the costs of any medical care/treatment I have hereby authorized.*

Health History (Check all that apply.)

Diseases	**Allergies**		**Chronic or Recurring Illness**	
☐Chicken Pox	☐Animals	☐Drugs	☐Ear Infections	☐Bed Wetting
☐Measles	☐Food	☐Plants	☐Heart Defect/Disease	☐Diabetes
☐German Measles	☐Hay Fever	☐Pollen	☐Seizures/Convulsions	☐Musculoskeletal Disorders
☐Mumps	☐Insect Stings	☐Other (Specify) _____	☐Bleeding Disorders	☐Arthritis
☐Rheumatic Fever	☐Medicine		☐Asthma	☐Sinusitis
☐Tuberculosis	☐Asthma		☐Mononucleosis	☐Frequent Headaches
☐Kidney	☐Penicillin		☐Fatigue	☐Other _____

My camper has permission to take or use the following over-the-counter medications at day camp if provided by me in their original container with a Medication Administration Form and/or at resident camp, only when administered by an R.N. on staff and according to the Camp Physician's Standing Orders.

☐Tylenol/Acetaminophen	☐Benadryl /antihistamine	☐Hydrocortisone Cream
☐Advil/ Ibuprofen	☐Antidiarrheal	☐Hydrogen Peroxide
☐Antibiotic Ointment/Bacitracin	☐Robitussin/expectorant	☐Wound Wash
☐Antacids/Tums	☐Swimmer's Ear/alcohol-vinegar solution	☐Calamine/Caladryl

Restrictions (The following restrictions apply to this individual.)

Does not eat: ☐Red meat ☐Pork ☐Dairy products ☐Poultry ☐Seafood ☐Eggs ☐Peanuts ☐Other (describe)

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

General Questions (Please explain any "yes" answers, noting the number of the questions. Attach explanation, if needed.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	☐	☐	9. Have frequent nosebleeds?	☐	☐
2. Ever had a head injury?	☐	☐	10. Have a history of bedwetting?	☐	☐
3. Wear glasses, contacts, or protective eye wear?	☐	☐	11. Have any skin problems (e.g., itching, rash)?	☐	☐
4. Ever passed out during exercise?	☐	☐	12. Have problems with diarrhea/constipation?	☐	☐
5. Have problems with sleepwalking?	☐	☐	13. Have severe menstrual cramps?	☐	☐
6. Ever had emotional difficulties for which professional help was sought?	☐	☐	14. Have an orthodontic appliance being brought to activity?	☐	☐
7. Had an operation or serious injury?	☐	☐	15. Ever been hospitalized?	☐	☐
8. Had a chronic or recurring illness or medical condition?	☐	☐	**16. Have medications to take during/at camp?**	☐	☐

Health Information Privacy Statement and Permission to Treat.

The Camper/Staff Health Record is for health care concerns at summer camp only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor during summer camp. Minimal necessary information may be shared with camp staff in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event coordinator by the participant or her legal representative. 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.

This health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me and/or the examining physician. I hereby authorize the Girl Scouts of Connecticut (GSOFCT) and any medical personnel selected by the Camp to provide medical assessment and routine medical treatment/services to my child, including hospitalization, and necessary related transportation, and in case of an emergency, authorize the provision of medically necessary treatment/services, including transfer to a hospital or facility for emergency treatment/services. I release GSOFCT and its officers, directors, employees, personnel, agents, and contractors, from and against any and all claims and liability arising from or related to the provision, authorization and administration of medical treatment, services and medication to my child. My child has not had any serious illness, injury or operation since the day of her last medical examination.

Signature of Parent/Guardian or Staff Member _____ Date _____

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CAMP NAME:

SESSION DATES:

CAMPER/STAFF HEALTH RECORD - HEALTH EXAMINATION AND IMMUNIZATION

- **To be filled in by physician** after review of health history with parent/guardian/staff member.
- The health examination must be completed within the 24 months preceding participation in summer camp.
- If you wish to use this form for other purposes, you should copy it prior to sending it to GSOFCT. GSOFCT maintains forms as required by law, but requires new submission of form annually.

Mail completed health record to:
Girl Scouts of Connecticut
Outdoor Program Department
20 Washington Avenue
North Haven, CT 06473

Participant Name (Last, First, Initial)	Date of Examination

Health Examination (This part is to be filled in by physician after review of health history with parent/guardian.)

Height	Weight	Blood Pressure	Appearance-Nutrition

Eyes: Without Glasses	Left: 20/___	Right: 20/___	With Glasses	Left: 20/___	Right: 20/___

Color Vision:	
Ears: Hearing: Right:	Left:

Code: Satisfactory: **S** Not Satisfactory: **X** Not Examined: **O**

Nose	Genitalia
Throat	Hernia
Teeth	Skin
Heart	Musculoskeletal
Lungs	Physical/ emotional status
Abdomen	Urinalysis*

Physician's Comments

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

Current Treatment (include current medications):

Explanation of any reported loss of consciousness, convulsion or concussion:

Does the applicant have epilepsy? ☐ Yes ☐ No

Does the applicant have diabetes? ☐ Yes ☐ No

* Not required for every health examination. A girl 5-10 should have this test if she has not already had it, either when entering school or at any time since. A girl 11-18 should have this test if she has not had it since entering puberty.

Record of Immunizations

Immunization	Year Primary Series Completed	Year of Last Booster	Immunization	Year Primary Series Completed	Year of Last Booster
DTaP			Oral Polio		
Diphtheria			Measles		
Pertussis (Whooping Cough)			Mumps		
Tetanus			Rubella		
Hep B**			Chicken Pox		
Td***			Meningitis		

Tuberculin test - year last given	Result
Other	**Effective January 1, 1999, for all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required (105CMR430.155(4). ***Adult tetanus-diphtheria toxoid

Medications taken or needed during camp

At Day Camp – all medications must be provided by the family of the participant accompanied by the completed Medication Administration Authorization Form that is signed by the participant's physician.
At Resident Camp – all prescription medications must be provided by the family of the participant accompanied by the completed Medication Administration Authorization Form that is signed by the participant's physician.
At Resident Camp - over-the-counter medications may be administered by the qualified health staff, following Physician's Standing Orders.

Physician's Recommendations

Has the applicant been on any medication within the last six (6) months? ☐ Yes ☐ No If yes, please explain:

For female: Has this person menstruated? ☐ Yes ☐ No If not, has she told you about it? ☐ Yes ☐ No If yes, is her menstrual history normal? ☐ Yes ☐ No

Physician's Recommendations and Restrictions While at Camp

Any treatment to be continued at camp:

Any Medications to be administered at camp:

Any medically prescribed meal plan or dietary restrictions:

Any allergies (food, drug, plants, insects, animals, etc.):

Any physical activity to be restricted?

Additional health information:

This person is in satisfactory condition and may engage in all usual activities, except as noted.

Licensed physician's name	Licensed physician's signature

City ST Zip Code

Phone Date