HEALTH HISTORY FORM

UNIT:_____

Camp Attending: _____

Session(s): _____

Dates: _____

Health Screening
(For Office Use Only)

1. How are you feeling today?
2. Have you recently had or been exposed to pink eye, head lice, or the flu?
3. Do you have any fevers, rashes, or allergies that we should know about?
4. Are there any updates to the health form?

Screening_____ Head Check_____

This part is to be filled out by the parent/guardian.

Name (Last, First, Initial)				Sex	Birth Date	Age
Address	**City or Town**	**State**	**Zip**	**Phone**		
				( )		
Parent/Guardian #1	**Parent/Guardian #1 Phone**		**Parent/Guardian #2**	**Parent/Guardian #2 Phone**		
	( )			( )		
Emergency Contact other than Parent	**Relationship**		**Phone**	**Alternate Phone**		
			( )	( )		

Insurance Information - *Please complete the following:*

Carrier	ID Number	Group Number
Member Services Phone Number	**Address**	
( )		
Primary Care Physician	**Primary Care Physician Phone**	
	( )	

Health History – *Please check if you have had any of the following:*

ILLNESS/HEALTH CONDITIONS
- ☐ Chicken Pox
- ☐ Measles
- ☐ German Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Mononucleosis
- ☐ Hearing Impairment
- ☐ Contacts/Glasses
- ☐ Migraines

- ☐ ADD/ADHD
- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Seizures
- ☐ Bleeding Disorders
- ☐ Asthma
- ☐ Hypertension
- ☐ Diabetes
- ☐ Musculoskeletal Disorders
- ☐ Arthritis
- ☐ Sinusitis
- ☐ Eating Disorders

Other_____

ALLERGIES
- ☐ Animals_____
- ☐ Food _____
- ☐ Hay Fever_____
- ☐ Insect Bites/Stings_____
- ☐ Medicine/Drugs _____
- ☐ Pollen_____
- ☐ Other (Specify) _____

My daughter has permission to take or use the following:
- ☐ Tylenol/Acetaminophen
- ☐ Advil/Ibuprofen
- ☐ Sudafed/Decongestant
- ☐ Benadryl/Antihistamine
- ☐ Tums/Antacid
- ☐ Robitussin/Expectorant
- ☐ Calamine Lotion/Itch Relief
- ☐ Cough Drops
- ☐ Midol/Menstrual Cramp Relief
- ☐ Aloe Vera
- ☐ Bacitracin
- ☐ Immodium
- ☐ Desinex/Tinactin Powder

Please describe conditions and give dates:

Does the participant currently have tubes in their ears? ___ No ___ Yes If yes, how long have they been in? _____

Any operations or serious injuries? _____

Any hospitalizations? _____

Any other diseases or disabilities? _____

Please comment where applicable:

Fainting _____
Bedwetting _____
Constipation _____
Emotional Disturbances _____
Specific Activities to be Encouraged _____
Sleeping Disturbances/Disorders _____
Menstrual Cramps _____
Severe Nosebleeds _____
Other _____
Restricted _____
Dietary Regimen to be Followed _____

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp_____

HEALTH HISTORY FORM

Please list the date of camper's last Tetanus vaccine (This is required for all attendees):

Month_____ Year_____

Please initial next to **one** of the following:

_____ I attest that all of the camp attendee's immunizations (as required for school) are up to date.

_____ Camp attendee has not received immunizations for religious or other reasons. (Please contact the Camp Director to obtain and complete an immunization waiver. The waiver is required for camp attendance.)

CAMPER MEDICATIONS

Please list all medications including prescription, over the counter, and as needed medications.

1	Medication	Dosage	Time taken (Check all that apply):			
			Brkfast	Lunch	Dinner	Bedtime
	Reason for taking and special instructions					
2	Medication	Dosage	Time taken (Check all that apply):			
			Brkfast	Lunch	Dinner	Bedtime
	Reason for taking and special instructions					
3	Medication	Dosage	Time taken (Check all that apply):			
			Brkfast	Lunch	Dinner	Bedtime
	Reason for taking and special instructions					
4	Medication	Dosage	Time taken (Check all that apply):			
			Brkfast	Lunch	Dinner	Bedtime
	Reason for taking and special instructions					
5	Medication	Dosage	Time taken (Check all that apply):			
			Brkfast	Lunch	Dinner	Bedtime
	Reason for taking and special instructions					

IMPORTANT – The following must be complete for camp attendance.

Permission to Provide Necessary Treatment or Emergency Care: I hereby give my permission to medical personnel selected by Girl Scouts Western Pennsylvania to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by Girl Scouts Western Pennsylvania to secure and administer treatment, including hospitalization for the person named above. This health history form is complete to the best of my knowledge, and the person herein described has permission to engage in all program activities, except as noted. This completed form may be photocopied.

Parent/Guardian Signature _____ Date _____