

Girl Scouts of the Sierra Nevada

Health History and Examination Form for Children and Adults Attending Camps

The information on this form is gathered to provide camp health care personnel the background necessary to provide appropriate care. Please provide complete and correct information. Keep a copy of the completed form for your records. This form, except for the "Health Recommendations of Licensed Medical Personnel," is to be filled in by parents/guardians of minors or by adults themselves.

Participant Information:

Name _____ Birth date _____ Age at camp _____
Last First Middle

Home address _____
Street address City State Zip

Social Security Number of participant _____ Gender: Female Male

Parent/Guardian Emergency Contact Information:

First Custodial Parent/Guardian _____

Telephone: Day _____ Evening _____ Cell _____

Second Custodial Parent/Guardian _____

Telephone: Day _____ Evening _____ Cell _____

If not available, in an emergency, notify: _____ Relationship: _____

Telephone: Day _____ Evening _____ Cell _____

Insurance Information:

Is the participant covered by family medical/hospital insurance? Yes No (**Please attach copy of insurance card.**)

If so, indicate carrier or plan name _____

Group _____ Insurance ID number _____

Name of insured _____ Relationship to participant _____

Medical Providers:

Name of family physician _____ Telephone _____

Address _____

Name of family dentist/orthodontist _____ Telephone _____

Address _____

Important – This box must be completed for attendance*

Parent/Guardian or Adult Authorization: This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I understand and agree to abide by any restrictions placed on my participant in camp activities.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I understand every effort will be made to contact me or the emergency contact noted above before taking this action. This completed form may be photocopied for trips out of camp.

Printed Name _____ Date _____

Signature _____

*If, for religious reasons, you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Allergy Information:

(List all known allergies – medication, food, and otherwise.)

Allergic to: _____ Describe reaction and management of the reaction.

Chronic/Recurring Illness: (Circle all that apply.)

- | | | |
|--------------------------|-----------------------|-------------|
| Diabetes | ADD/ADHD | Lice |
| Bedwetting | Ear Infections | Seizures |
| Hypertension | Eating Disorders | Fainting |
| Musculoskeletal Disorder | Back Pain | Headaches |
| High Blood Pressure | Heart Defect | Asthma |
| Diarrhea/Constipation | Sleep Disorder | Nose Bleeds |
| Menstrual Cramps | Other (Specify) _____ | |

List important details of noted items: _____

Dates of operations or serious injuries: _____

Restrictions:

Dietary _____

Physical _____

Name _____ Date _____ Program _____ Year _____

