



**MEDICAL HISTORY FORM FOR
EVENTS OF TWO NIGHTS OR LESS
OR THREE NIGHTS OVER A
FEDERAL HOLIDAY**

Girl Scouts of Silver Sage Council
1410 Etheridge Lane
Boise, ID 83704
(208) 377-2011 or (800) 846-0079
www.girlscouts-ssc.org

To be completed for all campers, Adult and Child:

Name _____ Birth date ____/____/____

Address _____ City _____ St _____ Zip _____

Troop Leader's Name _____ Troop # _____

Emergency Contact Name _____ Relationship _____

Phone number(s) _____

As parent or legal guardian of this child, I give my permission for her/him to attend camp and participate in all activities. I certify that to the best of my knowledge my child is in good health and able to participate at camp. I understand that my child cannot bring medication to camp unless it is prescribed by a physician and is in the original container. My child may be transported out of camp for program activities. I give my permission for my child to receive medical treatment in case of injury or illness en route to, from, or during camp.

Signature of Custodial Parent or Legal Guardian (required)

Health History (check if applicant has had any of the following)

- | | | | | | |
|---|--|---|--|---|---------------------------------|
| <input type="checkbox"/> Eyesight Impairment | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Intestinal Disorders | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Measles | <input type="checkbox"/> Allergies to Medication | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hay Fever or Other Serious Allergies | <input type="checkbox"/> Disease of Ears | <input type="checkbox"/> Disease of Kidneys | <input type="checkbox"/> Mental or Emotional Disorders | | |
| <input type="checkbox"/> Menstrual Disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other Serious Medial Disorder | <input type="checkbox"/> Chronic diseases | |

Has applicant been hospitalized in the last five years? Yes No Is applicant taking any medication? Yes No

If any of the above has been checked, give nature of illness, dates, period of any disability, results and medications:

Name of Family Physician: _____ **Phone** _____

Date of applicant's last physical exam: _____ **Physician:** _____

Since applicant's last exam, has she/he had: (if so, please describe below)

- A serious injury Illness lasting longer than one week Operation Fracture Physician prescribed medication

Does applicant have any general physical limitation on activities which might limit participation in swimming, hiking or other strenuous activity? Yes No If overweight, will condition restrict activity? Yes No

List any special dietary needs: _____

Immunizations: fill in the dates of valid immunizations Applicant has had.

Polio-Complete series or Booster _____	Tetanus _____	German Measles _____
Rocky Mountain Spotted Fever _____	Cholera _____	Typhus _____
Typhoid and Para Typhoid _____	Yellow Fever _____	Small pox _____
Gamma Globulin (Hepatitis) _____	Other _____	

CAMP HEALTH SERVICES STAFF ONLY:

See log for camper during camp stay: Yes No

Medical condition upon arrival: _____