

HEALTH HISTORY FORMGirls and adults fill out only this side for events of two nights or less or three nights over a Federal holiday. See other side (Health Examination Form) for events lasting longer than that.

1410 Etheridge Lane Boise, ID 83704 (208) 377-2011 or (800) 846-0079 Fax: (208) 377-0504 www.girlscouts-ssc.org

Camper Name (Last, First, MI of girl or adult)				Parent/Guardian if camper is a minor			(Area Code) Phone			
Address			City		State Zip Co	ode	Date of Birth	Age	Sex: M or F	
Emergency Contact Person/Relationship				(Area Code) Phone				Work Phone		
Health History (d any of the	followi	ng)					
	DISEAS				5.1.	CHRONIC/REC				
Measles	Mumps		man Measles	5	Diabetes	Ear Infe		Musculoskeleta		
Hepatitis A	Hepatitis B	Hep	oatitis C		ADD/ADHD	Heart De	efect	Sleep Disorders	;	
Chicken Pox					Lice	Seizures		Menstrual Cran	ıps	
TR Test D	Date/Result:				Nose Bleeds	Asthma		Eating Disorder	'S	
Operation or seriou					Fainting	Hyperte	nsion	Other (Specify)	1	
Operation of serior	ALLERG	IFS			IMM	MUNIZATIONS (Use other side	e as needed)		
Animals Insect Stings Polle			Pollen		Are required school immunizations up to date? Yes □ No □					
			Other		If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being					
Hay Fever	Plants		00101		statement: I unders fully immunized.	stand and accep	it the risks t	o my child fro	m not being	
riay rever	riancs				runy minumzeu.					
					Signature of Adult Cam	per or Parent/Gu	ardian if camp	per is a minor	Date	
List important deta	ils, especially allerg	jic reactio	ns to stings,	food and	drugs: (Attach additional s					
Transport inform	estion monded in	of		e. Is no	rticipant covered by family i	madical/basnital i	incurance?	Yes □ No	0 🗆	
Insurance carrier o		case or c	emergencie	grou		name of ins		ies 🗆 No	<i></i>	
available at camp; whether or not we Over-the-Count	you do not need to have permission to ter (OTC) Medica	supply the administ	nem. <i>Unless</i> er over-the-c	s instruct counter (lease check all over-the-counted otherwise, we will follow OTC) medications if the need ant to receive or have my	y the directions of ed arises.	n the medicati	ion for dosage.	Please indicate	
	n (pain, fever)	Li \			o not want to receive or h	have my camper	receive any O	TC medications	without prior	
<u> </u>	in, fever, inflamma ine (decongestant)			pern	nission from me.					
	nine (decongestant)									
Dextromethor	•	-)								
Calamine Lotio				Signati	ure of Adult Camper or Pare	ent/Guardian if ca	mper is a mir	nor	Date	
Antacid Tablets (upset stomach)			·							
must be in <i>origina</i> sickness, mosquito	al container with r bite relief, etc. Planeeds to carry and space, please attach	name, ado ace all lab administe	dress of camp eled meds (p er own medica	per, phar prescriptions fo	c) MEDICATIONS YOU macy, dosage and frequence on and over-the-counter) in remergency treatment such ving information. Reason for Medica	cy. This includes a a plastic zipper t h as bronchial inh	OTC vitamins, pag with camp	, medications fo per's name on th	r motion ne bag. Please ications.	
								_ Yes □	No □	
								_ Yes □	No □	
								Yes □	No □	
								_ Yes □	No □	
is in good health. reached in an emer to be hospitalized,	I give permission to rgency, I give my p if necessary. It is a ng taken by campe npleted form may l	o receive permission understoo r are liste be photoc	or have my camp of for my camp od every effor d on this forr opied for trip	amper reper t will be m. I agress away f	er has permission to engage eceive treatment for routine, to receiv made to contact me or the ee to the release of any recommon camp. I agre	e medical and/or for the emergency med emergency contactords necessary for	first aid needs dical treatmen act noted abov or treatment, r	. In the event Int and surgical to ve, before taking	cannot be reatment and g this action. or insurance	
Signature of Audit		Juui ulai l	n camper is a	4 11111101		Dute				

Required for events lasting more than 3 days

HEALTH EXAMINATION FORM PHYSICIAN STATEMENT

see below for exemption *

Girls and adults attending more than three (3) days of supervised Girl Scout activities are required to have a health exam current within the last 24 months. Contact us if you have turned in a health exam recently. If current you need to update the Health History form (other side), but not get a new exam.

	Health Examina	tion:	Please give a	Please give all dates of immunization for:						
Date of Examinat	tion:		Vaccine:	Dates ser Mo/Yr	ies completed/ Mo/Yr	/booster Mo/Y				
	don.		DTaP/Tdap	,	110/11	110/1				
Height:			(Diphtheria/Tetanus/Pertussis DT/Td)						
Weight:			(Diphtheria/Tetanus)							
Pulse Rate:			MMR (Measles/Mumps/Rubella	a)						
BP:			Polio (IPV and or OPV)							
			Hepatitis B							
Hearing: R			Hepatitis A							
yes: With Glasse	es R20/L20		Varicella (Chicken Pox)							
Vithout Glasses	R20/L20/		,							
			Meningococcal Meningitis (MCV4/MPSV4)							
			Haemophilus influenza B							
			Other:							
			Description of any current phy	Description of any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp? Yes \(\Bar{\text{Ves}} \) No \(\Bar{\text{U}} \)						
Code: S=Satisfa	ctory NS =Not Satisfactory	NE=Not Examined	requiring medication, treatme							
Nose	Abdomen	General Physical State	· ·							
Throat	Hernia	General Emotional Sta	If ves, please explain:							
Teeth	Appearance/Nutrition	Other:	-							
Heart	Skin		-							
Lungs	Musculoskeletal		-							
			_							
Comments and R	Recommendations:									
DUVETCTAN T	NFORMATION:									
	n or Nurse Practitioner: (Las	st, First, Middle Initial)		Phone Number:	none Number:					
Address:		Cir	.y:	ST:	Zip Code:					
		G	-y. 	31.	Zip code.					
This person is i	n satisfactory condition a	nd may engage in all us	sual activities, including physically de	emanding activitie	s except as r	noted.				
Signature of Lig	censed Physician or Nurse	Practitioner:		[Date:					
J	,									
OR										
EXEMPTION:										
ou may object			illosophical or religions reasons. If s No medical examination	so, indicate below	and sign:					
	⊔ NO	IIIIIIIIIIIZACION U	NO INCUICAL EXAMINATION							
ignature of Adul	It Camper or Parent/Guardian	if camper is a minor	Date							