Girl Scouts of Silver Sage
8948 W Barnes St
Boise, ID 83709
(208) 377-2011 or (800) 846-0079
Fax: (833) 790-5138
www.girlscouts-ssc.org

HEALTH HISTORY FORM

Girls 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.

Camper Name (Last, First, MI of girl or adult) | Parent/Guardian if camper is a minor | (Area Code) Phone

Address | City | State | Zip Code | Date of Birth | Age | Sex: M or F

Emergency Contact Person/Relationship | (Area Code) Phone | Cell Phone | Work Phone

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

DISEASES

___ Measles ___ Mumps ___ German Measles
___ Hepatitis A ___ Hepatitis B ___ Hepatitis C
___ Chicken Pox

_____ TB Test Date/Result: _____

Operation or serious injuries (dates):

CHRONIC/RECURRING ILLNESS

___ Diabetes ___ Ear Infections ___ Musculoskeletal Disorder
___ ADD/ADHD ___ Heart Defect ___ Sleep Disorders
___ Lice ___ Seizures ___ Menstrual Cramps
___ Nose Bleeds ___ Asthma ___ Eating Disorders
___ Fainting ___ Hypertension ___ Other (Specify)

ALLERGIES

___ Animals ___ Insect Stings ___ Pollen
___ Food ___ Medicine ___ Other
___ Hay Fever ___ Plants

IMMUNIZATIONS (Use other side as needed)

Are required school immunizations up to date? Yes ☐ No ☐

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 fully immunized.

_____
Signature of Adult Camper or Parent/Guardian if camper is a minor Date

List important details, especially allergic reactions to stings, food and drugs, and any camp activities from which your camper should be exempted for health reasons: (Attach additional sheet if needed.)

List any current and past physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp: (Attach additional sheet if needed.)

Insurance information needed in case of emergencies: Is participant covered by family medical/hospital insurance? Yes ☐ No ☐
Insurance carrier or plan name_____ group #_____ name of insured_____

MEDICATION PERMISSION RELEASE

We have Health Services Staff on site while campers are at camp. Please check all over-the-counter (OTC) medications camper is allowed to use. These are available at camp; you do not need to supply them. *Unless instructed otherwise, we will follow the directions on the medication for dosage.* Please indicate whether or not we have permission to administer over-the-counter (OTC) medications if the need arises.

	Over-the-Counter (OTC) Medications	Dosage
	Acetaminophen (pain, fever)	
	Ibuprofen (pain, fever, inflammation)	
	Pseudoephedrine (decongestant)	
	Diphenhydramine (antihistamine)	
	Dextromethorphan (cough)	
	Calamine Lotion (anti-itch)	
	Antacid Tablets (upset stomach)	

☐ **I want** to receive or have my camper receive listed OTC medications if the need arises.
☐ **I do not want** to receive or have my camper receive any OTC medications without prior permission from me.

_____
Signature of Adult Camper or Parent/Guardian if camper is a minor Date

ANY PRESCRIPTION and OVER-THE-COUNTER (OTC) MEDICATIONS YOU ARE SENDING TO CAMP WITH YOUR CAMPER must be in ***original container*** with name, address of camper, pharmacy, dosage and frequency. This includes OTC vitamins, medications for motion sickness, mosquito bite relief, etc. Place all labeled meds (prescription and over-the-counter) in a plastic zipper bag with camper's name on the bag. Please indicate if camper needs to carry and administer own medications for emergency treatment such as bronchial inhaler, EpiPen or diabetes medications. If you need more space, please attach separate sheet with the following information.

Medication (Name of Drug) | Reason for Medication | Emergency Self Medicate?

_____ Yes ☐ No ☐
_____ Yes ☐ No ☐

Consent: This health history is correct as far as I know, and camper has permission to engage in all prescribed camp activities, except as noted. Camper is in good health. I give permission to receive or have my camper receive treatment for routine medical and/or first aid needs. In the event I cannot be reached in an emergency, I give my permission for my camper _____, to receive emergency medical treatment and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action. All medications being taken by camper are listed on this form. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. This completed form may be photocopied for trips away from camp. ☐ **I agree or** ☐ **I do not authorize medical consent.**

_____ _____
Signature of Adult Camper or Parent/Guardian if camper is a minor Date

Required for events lasting more than 3 days

HEALTH EXAMINATION FORM
PHYSICIAN'S 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.

Camper Name (Last, First, MI of girl or adult):

Health Examination:	Please give all dates of immunization for:			
Date of Examination:	Vaccine:	Dates series completed/booster Mo/Yr	Mo/Yr	Mo/Yr
Height:	DTaP/Tdap (Diphtheria/Tetanus/Pertussis)			
Weight:	DT/Td (Diphtheria/Tetanus)			
Pulse Rate:	MMR (Measles/Mumps/Rubella)			
BP:	Polio (IPV and or OPV)			
Hearing: R L	Hepatitis B			
Eyes: With Glasses R20/_____ L20/_____	Hepatitis A			
Without Glasses R20/_____ L20/_____	Varicella (Chicken Pox)			
	Meningococcal Meningitis (MCV4/MPSV4)			
	Haemophilus influenza B			
	Other:			

Code: S=Satisfactory NS =Not Satisfactory NE=Not Examined

	Nose		Abdomen		General Physical State
	Throat		Hernia		General Emotional State
	Teeth		Appearance/Nutrition		Other:
	Heart		Skin		
	Lungs		Musculoskeletal		

Description of any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp? Yes ☐ No ☐

If yes, please explain:

Comments and Recommendations:

PHYSICIAN INFORMATION:

Licensed Physician or Nurse Practitioner: (Last, First, Middle Initial)		Phone Number:	
Address:	City:	ST:	Zip Code:

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

Signature of Licensed Physician or Nurse Practitioner: _____ Date: _____

OR

***EXEMPTION:**

You may object to immunizations or medical examinations for philosophical or religions reasons. If so, indicate below and sign:

☐ **No immunization** ☐ **No medical examination**

_____ _____

Signature of Adult Camper or Parent/Guardian if camper is a minor Date