



Girl Scouts of the Northwestern Great Lakes, Inc.

HEALTH HISTORY FORM

The Troop Leader must retain a copy of Health History Form for each troop member and keep ALL information CONFIDENTIAL. Adults completing this form may sign for themselves on the Parent/Guardian signature line. The Physical Exam Information portion of the form is required ONLY for attending Council camps or programs with three or more overnights. For Council-Wide or Council-Sponsored events; submit this form on or before the event. For camp: submit this form to camp staff on the first day. PARTICIPANTS WILL NOT BE ABLE TO ATTEND CAMP OR PROGRAM WITHOUT THIS COMPLETED FORM.

Name: Last First Middle D.O.B. Age at camp
Street Address City/State/Zip Male Female
Custodial Parent/Guardian Day/Work Phone Evening/Home Phone Cell/Mobile Phone
2nd Parent/Guardian/Emergency Contact Day/Work Phone Evening/Home Phone Cell/Mobile Phone
Street Address City/State/Zip
If not available in emergency, notify Relationship Phone

Insurance Information: Is the participant covered by family medical/hospital insurance? Yes or No

If yes, indicate carrier or plan name Group # ♦ Photocopy of front and back of health insurance card must be attached to this form.

ALLERGIES: List all known (medication, food, or other allergies)

Describe reaction and management of the reaction.

Blank lines for listing allergies and describing reactions.

GENERAL QUESTIONS (Explain "yes" answers below.)

Table with 6 columns: Question, Yes, No, Question, Yes, No. Contains 28 health-related questions.

Please explain any "yes" answers, noting the number of the questions:

Which of the following has the participant had?
Measles German measles Chicken Pox Mumps
Hepatitis A Hepatitis B Hepatitis C

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware: _____

Table for immunization dates: Please give all dates of immunization for: Month/year. Rows include DTP, TD, Tetanus, Polio, MMR, Or Measles, Or Mumps, Or Rubella, Haemophilus influenza B, Hepatitis B, Varicella (chicken pox).

Important - SIGNATURE REQUIRED FOR ATTENDANCE
Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp / Girl Scouts of the Northwestern Great lakes, Inc. to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp / Girl Scouts of the Northwestern Great lakes, Inc. to arrange necessary related 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 / Girl Scouts of the Northwestern Great lakes, Inc. to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult volunteer/camper/ staffer Date

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Complete this portion of the Health History Form if participant is attending Council Camps or programs with three or more overnights.

This section requires the signature of licensed medical personnel.

PHYSICAL EXAM INFORMATION

The Physical Exam Information section of this form is required for ALL girls attending any camp with 3 or more overnights.

*A physical exam must be completed by approved licensed medical personnel at least every two years (if you would like to use this form more than one year, **please keep a copy in your records**).*

Health Care Recommendations by Licensed Medical Personnel

Date of Exam

Blood Pressure

Weight

Height

In my opinion, the above applicant is able to participate in an active camp program: Yes or No

The applicant is under care of a physician for the following conditions: _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Medications to be administered at camp (name, dosage, frequency): _____

Any adverse reactions to medications?: _____

Any medically prescribed meal plan or dietary restrictions: _____

Known allergies: _____

Description of any limitation or restriction on camp activities: _____

Additional information for health care staff at the camp: _____

Signature of Licensed Medical Personnel:

Printed

Title

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Phone

Date

Street Address

City/State/Zip