In accordance with the provisions of 105 CMR 430.000 Minimum Sanitation and Safe Standards for Recreational Camps for Children, Massachusetts State Sanitary Code, Chapter IV.

GIRL SCOUTS OF CONNECTICUT

www.gsofct.org 1-800-922-2770

CAMP NAME:

SESSION DATES:

GIRL/STAFF HEALTH RECORD - HEALTH HISTORY

To be completed by parent/guardian or staff member, as applicable.

This form should provide current information for summer camp.

Complete and bring form with you on the first day of each summer camp session. Keep one copy for yourself.

Participant Information

Name (Last, First, Initial)	Parent/Guardian	Birth date	Age
Address	City	ST	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
In Emergency Notify	Address	Relationship to Girl	
Home Phone ( )	Work Phone ( )	Cell Phone ( )	

Insurance Information (List your primary policy. This information may be released, if necessary, for insurance purposes.)

Carrier	ID Number	Group Number
Member Services Phone Number	Address	

A. Health History (Check all that apply.)

Diseases	Allergies		Chronic or Recurring Illness	
☐Chicken Pox	☐Animals	☐Drugs	☐Ear Infections	☐Bed Wetting
☐Measles	☐Food	☐Plants	☐Heart Defect/Disease	☐Diabetes
☐German Measles	☐Hay Fever	☐Pollen	☐Seizures/Convulsions	☐Musculoskeletal Disorders
☐Mumps	☐Insect Stings	☐Other (Specify) ______	☐Bleeding Disorders	☐Arthritis
☐Rheumatic Fever	☐Medicine	☐Specify details of food or drug allergies _______	☐Asthma	☐Sinusitis
☐Tuberculosis	☐Asthma		☐Mononucleosis	☐Frequent Headaches
☐Kidney	☐Penicillin		☐Fatigue	☐Other ______

My daughter has permission to take or use the following, if available or if provided by me in their original container. During summer camp, over-the-counter medications may only be administered in an emergency when an R.N. is the camp's Director of First Aid and according to the Camp Physician's Standing Orders.)

☐Tylenol/Acetaminophen	☐Benadryl/antihistamine	☐Hydrocortisone Cream
☐Antibiotic Ointment/Bacitracin/Bactoban	☐Antidiarrheal	☐Hydrogen Peroxide
☐Antacids	☐Tums/antacid	☐Epinephrine
☐Calamine/Caladryl	☐Robitussin/expectorant	☐Epi-Pen Jr. (up to 9 years of age)
☐Wound Wash	☐Swimmer's Ear/alcohol-vinegar solution	☐Epi-Pen (over 9 years of age)

Restrictions (The following restrictions apply to this individual.)

Does not eat: ☐Red meat ☐Pork ☐Dairy products ☐Poultry ☐Seafood ☐Eggs ☐Peanuts ☐Other (describe)

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary). Attach explanation, if needed.

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	☐	☐	9. Have frequent nosebleeds?	☐	☐
2. Ever had a head injury?	☐	☐	10. Have a history of bedwetting?	☐	☐
3. Wear glasses, contacts, or protective eye wear?	☐	☐	11. Have any skin problems (e.g., itching, rash)?	☐	☐
4. Ever passed out during exercise?	☐	☐	12. Have problems with diarrhea/constipation?	☐	☐
5. Have problems with sleepwalking?	☐	☐	13. Have severe menstrual cramps?	☐	☐
6. Ever had emotional difficulties for which professional help was sought?	☐	☐	14. Have an orthodontic appliance being brought to activity?	☐	☐
7. Had an operation or serious injury?	☐	☐	15. Ever been hospitalized?	☐	☐
8. Had a chronic or recurring illness or medical condition?	☐	☐			

Please explain any "yes" answers, noting the number of the questions. Attach explanation, if needed.

Health Information Privacy Statement

The Girl/Staff Health Record is for health care concerns at summer camp only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor during summer camp. Minimal necessary information may be shared with camp staff in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event coordinator by the participant or her legal representative. I have read the above procedures for handling the health form information, and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by the Camp Director to order X-rays, routine tests, treatment including hospitalization, and necessary related transportation for my daughter. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. My daughter has not been exposed to any contagious diseases within at least one week before coming to camp and has not had any serious illness or operation since the day of her last medical examination. The forms may be copied for trips out of camp.

Signature of Parent/Guardian/Staff Member ______________________ Date ______________

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GIRL/STAFF HEALTH RECORD - HEALTH EXAMINATION AND IMMUNIZATION

To be filled in by physician after review of health history with parent/guardian/staff member.
This form must be completed within the 24 months preceding a girl's participation in summer camp.

Complete and bring form with you on the first day of each summer camp session. Keep one copy for yourself.

Girl Name (Last, First, Initial)	Date of Examination

Health Examination (This part is to be filled in by physician after review of health history with parent/guardian.)

Height	Weight	Blood Pressure	Appearance-Nutrition

Eyes: Without Glasses	Left: 20/___	Right: 20/___	With Glasses	Left: 20/___	Right: 20/___

		Physician's Comments
Color Vision:		The applicant is under the care of a physician for the following conditions:
Ears: Hearing: Right:	Left:	
Code: Satisfactory: S Not Satisfactory: X Not Examined: O		
Nose	Genitalia	Current Treatment (include current medications):
Throat	Hernia	
Teeth	Skin	Explanation of any reported loss of consciousness, convulsion or concussion:
Heart	Musculoskeletal	
Lungs	Physical/ emotional status	Does the applicant have epilepsy? ☐ Yes ☐ No
Abdomen	Urinalysis*	Does the applicant have diabetes? ☐ Yes ☐ No

* Not required for every health examination. A girl 5-10 should have this test if she has not already had it, either when entering school or at any time since. A girl 11-18 should have this test if she has not had it since entering puberty.

Record of Immunizations

Immunization	Year Primary Series Completed	Year of Last Booster	Immunization	Year Primary Series Completed	Year of Last Booster
DTaP			Oral Polio		
Diphtheria			Measles		
Pertussis (Whooping Cough)			Mumps		
Tetanus			Rubella		
Hep B**			Chicken Pox		
Td***			Meningitis		

Tuberculin test - year last given	Result
Other	**Effective January 1, 1999, for all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required (105CMR430.155(4). ***Adult tetanus-diphtheria toxoid

When an R.N. is the camp Director of First Aid, I give permission to administer the medication marked below, according to the Camp Physician's Standing Orders.

☐Tylenol/Acetaminophen	☐Benadryl/antihistamine	☐Hydrocortisone Cream
☐Antibiotic Ointment/Bacitracin/Bactoban	☐Anti-diarrheal	☐Hydrogen Peroxide
☐Antacids	☐Tums/antacid	☐Epinephrine
☐Calamine/Caladryl	☐Robitussin/expectorant	☐Epi-Pen Jr. (up to 9 years of age)
☐Wound Wash	☐Swimmer's Ear/alcohol-vinegar solution	☐Epi-Pen (over 9 years of age)

Physician's Recommendations

Has the applicant been on any medication within the last six (6) months? ☐ Yes ☐ No If yes, please explain:

For female: Has this person menstruated? ☐ Yes ☐ No If not, has she told you about it? ☐ Yes ☐ No If yes, is her menstrual history normal? ☐ Yes ☐ No

Physician's Recommendations and Restrictions While at Camp

Any treatment to be continued at camp:

Any Medications to be administered at camp (specific dosages):

Any medically prescribed meal plan or dietary restrictions:

Any allergies (food, drug, plants, insects, etc.):

Any physical activity to be restricted?

Additional health information:

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

Licensed physician's name	Licensed physician's signature

City ST Zip Code

Phone____ Date ______________________________________

If over-the-counter or prescription medications may be taken at summer camp, PLEASE COMPLETE, SIGN, AND ATTACH THE **CAMP MEDICATION ADMINISTRATION AUTHORIZATION FORM.** INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g., food, medications, environmental).