girl scouts

Girl Scouts of Western Washington

Community Camper Health History & Consent to Treat

Camper's Full Name: _____ Date of Birth: _____

Girl Scout Camp Attending: ❑Camp Lyle McLeod ❑Camp Juliette ❑Camp Towhee

Community Camp Name:_____ Program Dates: _____

Please attach extra sheets inside if you need more room to write.

Allergies

- ❑ No known allergies
- ❑ This camper is allergic to (*please list allergy and reactions-use additional sheets if necessary*):
  - ❑ Food
  - ❑ Medications
  - ❑ Environment (plants, insects)
  - ❑ Other (chemical, latex, etc)

❑ Check here to request follow up for Action Plan development with the Camp Nurse.

Diet and Nutrition

- ❑ This camper eats a regular diet
- ❑ This camper eats a regular vegetarian ❑ /vegan ❑ diet (please check which one)
- ❑ This camper has special food needs (*please describe below, attach sheet as needed*)

_____

_____

_____

Mental, Emotional and Social Health: Check "yes" or "no" for each statement

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? **Yes** ❑ **No** ❑
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? **Yes** ❑ **No** ❑
3. During the past 12 months, see a professional to address mental/emotional health concerns? **Yes** ❑ **No** ❑
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, other) **Yes** ❑ **No** ❑

Please Explain:

_____

_____

_____

Camper Name: _____ Unit: _____ Community camp:: _____

General Health History

If any of the following statements apply to the camper, please check the box to indicate "Yes."
Has/Does the camper:

1. Ever been hospitalized? ❑	11. Had fainting or dizziness? ❑
2. Ever had surgery? ❑	12. Passed out/had chest pain during exercise? ❑
3. Have recurrent/chronic illnesses? ❑	13. Had mononucleosis ("mono") in the past 12 months? ❑
4. Had a recent infectious disease? ❑	14. Started menstruation? Any problems? ❑
5. Had a recent injury? ❑	15. Have problems with falling asleep or sleep walking? ❑
6. Ever had back/joint problems? ❑	16. Had asthma/wheezing/shortness of breath? ❑
7. Have diabetes? ❑	17. Have a history of bedwetting? ❑
8. Had seizures? ❑	18. Have problems with diarrhea/constipation? ❑
9. Had headaches? ❑	19. Wears glasses, contacts or protective eyewear? ❑
10. Have any skin problems? ❑	20. Traveled outside the country in the past 9 months? ❑

Please explain any "Yes" answers in the space below, noting the number of the question(s) *For travel outside the country, please name the countries visited and dates of travel. Use additional sheets if necessary.*

_____

_____

_____

_____

Note: Campers that have any serious illness, injury or surgery in the last 18 months need a physical exam. The Physician's Health Exam *form can be found on our website www.girlscoutsww.org.*

Restrictions

❑ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

❑ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations (*please describe below on a separate sheet).*

Anything else? ***Please provide on a separate sheet*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program.

Immunizations

Give the dates (year) of the last immunization or booster, or attach a copy of official immunization record.

_____ Tetanus _____Chicken Pox _____Measles/Rubella _____Mumps

_____ Flu _____Diphtheria/Pertussis (DTaP/DT) _____Hepatitis A _____Hepatitis B

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 Custodial Parent/Guardian:**_____ **Date:**_____

Contact the Community Camp Director:

Health Care Providers

Name of Camper's Physician_____ Phone _____

Name of Camper's Dentist_____ Phone _____

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides so the information is able to be read.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number_____

Medications

- ❑ This camper will not take any daily medications while attending camp
- ❑ This camper will take the following medications while at camp (Please list below. Attach an additional sheet as needed). Please include dosage and times.

Please remember to send medications with a provided Medication Form, in the original containers, with physician prescription details. Medications in other containers, such as daily pill reminders, will not be accepted.

_____

_____

_____

_____

Non-Routine Medications

Occasionally, campers contract minor medical conditions that can be treated by non-prescription medications. These are stocked in the camp Health Center and are used on an as needed basis under the Health Procedures signed by our Health Care Provider. Medications may be generic or the store brand equivalent. Medications that come in tablet form can also be administered in liquid form. **Highlight / Cross out / strike through those the camper should not be given:**

For Sunburn: Aloe vera

For Sunscreen: Rocky Mountain – Broad spectrum SPF 30

For Pain: Acetaminophen, Ibuprofen

For Cough/Cold: Pseudoephedrine, Phenol Spray or menthol lozenges, Guaifenesin and Dextromethorphan HBr

Insect bites or Poison Ivy & Oak with swelling: Diphenhydramine tablets or cream, Calamine/Caladryl lotion, Hydrocortisone Cream ≤ 1%

Digestive Upsets: Bismuth subsalicylate, Calcium Carbonate, Docusate Calcium, Magnesium Hydroxide, Loperamide HCl, Peppermints

Cuts, Scrapes, Splinters: Bacitracin / Neomycin / Polymyxin ointment

Athlete's Foot: Clotrimazole Cream

Note: Campers displaying symptoms of head lice will need to be treated at home and can return to camp when they are nit-free (usually 24 hours)

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize secure proper treatment for and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a 'need to know' basis with camp staff. I give permission to photocopy this form. In addition the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's adult volunteer about my child's health status.

☒ **Signature of Custodial Parent/Guardian:**_____ **Date:**_____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Emergency/ Family & Alternate Contact

Child's Name:_____
Last MI First

Address:_____
Street Apt City State Zip

	Parent / Guardian #1	Parent / Guardian #2
Name		
Address		
City, State, Zip		
Home Phone		
Work Phone		
Cell Phone		
Email		

Where can you be reached ***during camp***?_____
If you plan to be out of town, please attach your itinerary and contact numbers.

Emergency Contact – *In the event that the parents above cannot be reached**, list 2 contacts** to whom your child can be released during the session for whatever reason, and can make health care decisions on your behalf.*

	Emergency Contact #1	Emergency Contact #2
Name		
City, State, Zip		
Home phone		
Cell Phone		
Email		
Relationship		

Camper Essential Functions:

In order to attend our camps, campers must meet the following essential functions:

- Capable of mainstream in the public school system (does not require 1 on 1 guidance)
- Moves independently from place to place
- Effectively interacts in group-based and community living
- Is able to meet personal needs (bathing, toileting, dressing, diet mgmt., etc.)
- Capable of self-management of health needs.

If you have questions regarding your camper please contact the camp director. Accommodation for special needs, allergies, or current health complications my require physician exam and physician approval to participate, with additional action planning and support documentation with the camp health team.

CONSENT OF PARENT OR GUARDIAN:

As parent/guardian having legal custody of the camper named, who is voluntarily enrolled as a participant in the Girl Scouts of Western Washington community resident camp program. I agree to instruct my child to observe rules and regulations governing the activities. I understand that camping programs involve inherent risk and possible injury because of the nature of the activity, even when conducted in a safe manner. I give permission for her to attend camp and participate in all phases of the program including related transportation.

I understand that a statement of her good health is required before she may attend. As the parent or legal guardian of the above child, I have read the statements above, understand the information and agree to allow my daughter/ward to participate in camp.

☒_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN Date

Please save a copy of this document for your records (update as necessary prior to camp start date)
MUST PRINT AND PHYSICALLY SIGN to submit to the Camp.