

HEALTH HISTORY (Page 1 of 4)

HEALTH CARE INFORMATION					
Participant/Adult Participant/Staff Name					
Address					
Birth Date	Age	Grade Entering in Fall			
Custodial Care Information					
My child is under the custodial care of (CHECK ONE): <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father Only <input type="checkbox"/> Other <i>Name & Relationship</i> _____					
Contact Information					
Parent/Guardian Name					
Home Phone	Work Phone	Cell			
Parent/Guardian Name					
Home Phone	Work Phone	Cell			
Emergency Contact (Person to contact if parent/guardian cannot be reached in an emergency)					
Name		Relationship			
Home Phone	Work Phone	Cell			
Address					
Insurance Information					
Is the individual covered by family medical/hospital insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If yes—carrier/plan name		Group#			
Carrier Address					
Name of Insured					
Policy Holder's insurance policy ID#					
HEALTH HISTORY					
This information must be completed by the parent/guardian or adult or staff member to provide healthcare personnel with the background to provide appropriate care. Any chances should be shared with campo personnel upon arrival.					
ALLERGIES					
List all known (medications, food, insect stings, hay fever, etc.) and describe reaction and management of the reaction.	1.				
	2.				
	3.				
	4.				
	5.				
MEDICATIONS					
List all medications (including over-the-counter or non-prescription) the person takes routinely. Bring enough medication, in the original packaging/bottle with its prescription or over-the-counter label , to last the entire camp session. By completing this information, you are giving permission for camp staff to administer the medications listed.	Name	Med #1	Med #2	Med #3	Med #4
	Dosage				
	Specific times taken each day				
	Reason for taking				
	This individual takes the following medications:				
MENTAL/EMOTIONAL HEALTH					
The following mental, emotional, and psychological health information will help our professional staff prepare and provide the best care for participants.	This individual has an emotional health concern that will impact participation. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				
	This individual has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder . <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				
	This individual has a significant life event that continues to affect her/his life/health. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				

Health History (Page 2 of 4) – Participant's Full Name

GENERAL HEALTH INFORMATION					
Has/does the individual...		YES	NO	Has/does the individual...	
1.	Had recent injury, illness/infectious disease?			24.	Have problems with sleepwalking?
2.	Have a chronic or recurring illness/condition?			25.	Have an abnormal menstrual history?
3.	Ever been hospitalized?			26.	Have a history of bedwetting?
4.	Ever had surgery?			27.	Have an eating disorder?
5.	Have frequent headaches?			28.	Ever had emotional difficulties for which professional help was sought?
6.	Ever had a head injury?			29.	Had lice, ringworm, or scabies in the past 2 months?
7.	Ever been knocked unconscious?			30.	Has behavioral challenges (ADD, other)?
8.	Wear glasses, contacts, or protective eye wear?			31.	Had measles?
9.	Ever had frequent ear infections?			32.	Had mumps?
10.	Ever passed out during or after exercise?			33.	Had chicken pox?
11.	Ever been dizzy during or after exercise?			34.	Had hepatitis?
12.	Ever had seizures?			35.	Had German measles?
13.	Ever had chest pain during or after exercise?			36.	Had problems with diarrhea/constipation?
14.	Ever had high blood pressure?			If yes to any question, please explain, noting question number being referenced.	
15.	Ever been diagnosed with a heart murmur?				
16.	Ever had back problems?				
17.	Ever had joint problems (knees, ankles, etc)?				
18.	Brought an orthodontic appliance to camp?				
19.	Have any skin problems (itching, rash, acne, etc)				
20.	Have diabetes?				
21.	Have asthma?				
22.	Had mononucleosis in the past 12 months?				

Immunizations			
	Date		Date
DPT		TD (tetanus/diphtheria)	
Polio		MMR (Measels Mumps Rubella)	
Varicells (chicken pox)		Tetanus	
Hepatitis B		Haemophilus influenza B	
TB Mantoux test			

DOCTORS	
Date of last physical exam (include year):	
Physician	Phone
Dentist/Orthodontist	Phone

Special Dietary Restrictions			
The following Dietary restrictions apply to this individual.	<input type="checkbox"/> Does not eat red meat	<input type="checkbox"/> Does not eat pork	<input type="checkbox"/> Does not eat eggs
	<input type="checkbox"/> Does not eat poultry	<input type="checkbox"/> Does not eat seafood	<input type="checkbox"/> Does not eat dairy products
	<input type="checkbox"/> Other (describe)		

Special Activity Restrictions	
Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary)	

Over the Counter Medication Authorization	
I (parent/guardian) hereby give permission for camp staff to administer the following over-the-counter medications or generic equivalents if the onsite health care staff deems it necessary. Dosages will be administered according to directions on the product.	
<input type="checkbox"/>	Acetaminophen/Tylenol – Adult or Children (headache, menstrual cramps, muscle cramps, fever)
<input type="checkbox"/>	Ibuprofen – Adult or Children (headache, menstrual cramps, muscle cramps, fever, ear aches)
<input type="checkbox"/>	Tecnu/Rhullgel/Ivy Dry/Calamine lotion (poison ivy, bug bites)
<input type="checkbox"/>	Ludens Throat drops/Cipacol lozenges/Chloraseptic (sore throat)
<input type="checkbox"/>	Sudafed liquid or tablets (stuffy nose)
<input type="checkbox"/>	Children's Pepto-Bismol/Tums/Roloids (upset stomach/diarrhea)
<input type="checkbox"/>	Robitussin DM (cough)
<input type="checkbox"/>	Claritin, Claritin D (allergy symptoms)
<input type="checkbox"/>	Benadryl – Adult or Children - liquid or lotion (insect bites, allergy symptoms, allergic reaction)
<input type="checkbox"/>	Triple Antibiotic Cream/Neosporin (skin abrasions/minor cuts and burns)
<input type="checkbox"/>	Hydrocortisone cream (insect bites, sunburn)
<input type="checkbox"/>	Foille/Solarcaine/Aloe Vera Gel (sunburn)
<input type="checkbox"/>	Lamisil (athlete's foot)
<input type="checkbox"/>	Aveeno Oatmeal Bath (poison ivy)
<input type="checkbox"/>	Epsom Salt (muscle strains, skin irritations)
<input type="checkbox"/>	Desitin (skin irritations, heat rash)
<input type="checkbox"/>	Talcum Powder/Baby Powder (skin irritations, heat rash)
<input type="checkbox"/>	Hydrogen Peroxide (minor cuts, scrapes, burns)
<input type="checkbox"/>	Anbesol (tooth aches)
<input type="checkbox"/>	Campho-Phenique (cold sores, insect bites, sunburn)

Health History (Page 3 of 4)–Participant's Full Name_____

SIGNATURES IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE

This health history is correct and complete as far as I know. The person herein described has permission to engage in all prescribed camp activities except as noted. _____(Initials of Parent/Guardian/Adult/Staff)

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as “personal representatives” for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person’s ability to participate in camp activities; (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child’s health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp 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/Guardian/Adult/Staff _____

Printed Name _____ Date _____

* If for religious reason you cannot sign this, contact Girl Scouts of New Mexico Trails Council for a legal waiver which must be signed for attendance.

I agree to abide by the restrictions placed on my camp activities.

Signature of Minor/Adult /Staff _____ Date _____

Health History (Page 4 of 4)—Participant's Full Name_____

SECTION B: Health Care Recommendation/Physical Examination

*Necessary for all attendees staying for 4+ days or spending the night at Camp Rancho del Chaparral or Camp Elliott Barker.

I have examined the following camp participant:

Name: _____ Date: _____
Last Name First Name Middle Name

BP _____ Weight _____ Height _____

In my opinion, the above applicant IS ABLE NOT ABLE to participate in an active camp program.

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

Current treatment at the time of this report includes:

Recommendations and Restrictions at Camp

Treatment to be continued at camp:

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

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

Signature_____

Printed _____ Title _____

Address _____ Phone _____ Date _____