girl scouts of new mexico trails

2021 Summer Camp Health History

Use additional pages or attach records as necessary.

Personal Information

Camper/Staff/Volunteer Name:		
Address: Street		
City:	State:	ZIP:
Birth date:	Age (if under 18):	Grade in Fall 2018:

Custodial Care and Contact Information

(Required for participants under the age of 18)

My participant is under the custodial care of (check one): Both Parents Mother Only Father Only Other (list name and relationship)		
Parent/Guardian Name:		
Home Phone:	Work Phone:	Cell Phone:
Parent/Guardian Name:		
Home Phone:	Work Phone:	Cell Phone:

Emergency Contact

(Required for **ALL persons**. Must be different than above in case parent/guardian cannot be reached)

Name:		Relationship:
Home Phone:	Work Phone:	Cell Phone:
Address:		

Insurance Information

Is the participant covered by family medical/hospital insurance?	Yes No
If yes- carrier/plan name:	Group #:
Carrier Address:	
Name of Insured:	Policy holder's insurance policy ID#:

Doctor Information

Camper's Physician:		Phone:
Date of last physical exam:	M/D/Y	

Camper/Staff Name : _____ Program Date: _____

Health History

(Required for **ALL persons**)

This information will provide healthcare personnel with the background to provide appropriate care. Any changes should be shared with appropriate Troop/event/camp personnel.

Allergies:	List all known (medications, food, insect stings, hay fever, etc,) and describe reaction and management of the reaction.
No known allergies	

Medications: No Medications (circle if true)

List all medications (both prescription and non-prescription) the person takes routinely. Fill out and attach the Authorization to Administer Medications form for all of the medications you list below.

Medications: _____

_____

Bring enough medication in the ORIGINAL PACKAGING/BOTTLE with its prescription or over-the-counter label to last the entire event/camp session.
Only ORIGINAL PACKAGING will be accepted

By completing this information, you are giving permission for event/camp staff or the appointed first aider to administer the medications listed.

Summer Camp/Programs only: This participant takes the following medications during the school year which she does not/may not take during the summer:	

Mental / Emotional Health	This participant has had a significant life event that continues to affect their life/health. Yes No If yes, please explain: This participant has an emotional health concern that will impact their participation. Yes No If yes, please explain:
The following mental, emotional, and psychological health information will help our professional event/camp staff prepare and provide the best care for all participants.	

Immunizations:

	Date		Date		Date
DPT		TD (tetanus/diphtheria)		Polio	
Varicella (chicken pox)		MMR (measles/mumps/rubella)		Tetanus	
Hepatitis B		Haemophilus influenza B		COVID - 19	

Special Dietary Restrictions: No dietary restrictions (circle if true)

Does not eat: (circle) red meat pork poultry eggs dairy seafood gluten
Other notes:

****If you have questions about dietary accommodations please contact council****
email: customercare@nmgirlscouts.org OR call: 505-343-1040

Camper/Staff Name : _____ Program Date: _____

General Health Information

The participant has/had...		Y	N	The participant has/had...		Y	N
1	A recent injury, illness/infectious disease?			19	Brought an orthodontic appliance to camp?		
2	A chronic or recurring illness/condition?			20	Any skin problems (itching, rash, etc.)?		
3	Ever been hospitalized?			21	Diabetes?		
4	Ever had surgery?			22	Asthma?		
5	Frequent headaches?			23	Mononucleosis in the past 12 months?		
6	Ever had a head injury?			24	Problems with diarrhea/constipation?		
7	Ever been knocked unconscious?			25	Problems with sleepwalking?		
8	Wear glasses, contacts or protective eyewear?			26	An abnormal menstrual history?		
9	Ever had frequent ear infections?			27	An eating disorder?		
10	Ever passed out during or after exercise?			28	Behavioral challenges (ADD, other)?		
11	Ever been dizzy during or after exercise?			29	Measles?		
12	Ever had seizures?			30	Mumps?		
13	Ever had chest pain during or after exercise?			31	Chicken pox?		
14	Ever had high blood pressure?			32	Hepatitis?		
15	Ever been diagnosed with a heart murmur?			33	German measles?		
16	Ever had back problems?			34	COVID – 19?		
17	Ever had joint problems (knees, ankles, etc.)?			35	Lice, ringworm, or scabies in the past two months?		
18	Ever had nosebleeds (frequent, severe, or recurring)?						

If you answered yes to any question, please explain, noting question number being referenced (use additional paper as necessary and label with the number from above).

Permission for basic medical treatment

By checking off the following items, I (parent/guardian) hereby give permission for the Troop leader, event/camp staff, or appointed first aider to administer the marked over-the-counter medications or generic equivalents if the on-site health care personnel deems it to be necessary. Dosage will be administered according to directions on the product.

	Acetaminophen/Tylenol – Adult or Children (headache, menstrual cramps, muscle cramps, fever)		Ibuprofen – Adult or Children (headache, menstrual cramps, muscle cramps, fever, ear aches)
	Calamine lotion (poison ivy, bug bites)		Sore Throat Drops/Chloraseptic spray (sore throat)
	Triple Antibiotic Ointment (skin abrasions/minor cuts & burns)		Benadryl (diphenhydramine) – Adult or Children – topical and/or oral (insect bites, allergy symptoms, allergic reaction)
	Pepto-Bismol/Tums/Rolaids– Adult/Children (upset stomach/diarrhea)		Claritin or similar (ceterizine/loratidine/fexofenadine) (allergy symptoms)
	Sudafed PE (phenylephrine) liquid or tablets (stuffy nose)		Robitussin DM (cough)
	Talcum Powder/Baby Powder (skin irritations, heat rash)		Hydrocortisone cream (insect bites, sunburn)
	Solarcaine/Aloe Vera Gel (sunburn)		Antifungal Ointment (athlete's foot)
	Oatmeal Bath – Aveeno or similar (poison ivy)		Epsom Salt (muscle strains, skin irritations)
	A&D Ointment (skin irritations, heat rash)		Hydrogen Peroxide (minor cuts, scrapes, burns)
	Topical Oral Benzocaine (tooth aches)		Campho-Phenique (cold sores, insect bites, sunburn)

Camper/Staff Name : _____ Program Date: _____

– Important Signatures–

Must be Completed for Attendance

ALL Staff Members, Parents, Guardians, Volunteers, and Campers must submit a signed copy of this form

This health history is correct and complete as far as I know. The person herein described has permission to engage in all prescribed Girl Scout activities except as noted. **____ (Initials of Parents/Guardian/Adult Participant/Volunteer/Staff)**

I hereby give permission to the acting first aider (first aid trained troop volunteer, event/camp staff) 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 Troop/event/camp staff to arrange related transportation. **____ (Initials)**

I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is my intention that the troop leader or event/camp staff 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 troop/event/camp be treated as "personal representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. **____ (Initials)**

I hereby agree (pursuant to 45 CFR 164.510(b) to the disclosure to troop/event/camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the troop/event/camp representatives related to the person's ability to participate in program activities; (ii) in the case of minors, to provide relevant information to the troop/event/camp representatives to keep me informed of my child's health status. **____ (Initials)**

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the troop/event/camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. **____ (Initials)**

Signature of Staff Member/Parent/Guardian: _____ Date: _____

Printed Name:_____ Relationship to Camper (if applicable): _____

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

I understand that the activities offered as part of the Girl Scouts of New Mexico Trails' resident camps possess inherent risks and I agree to allow myself (or a child in my care) to participate while abiding by the restrictions placed on the event/camp activities as deemed appropriate by camp staff, the American Camp Association, and Girl Scouts of the USA.

Signature of Staff Member/Parent/Guardian: _____ Date: _____

Printed Name:_____ Relationship to Camper (if applicable): _____