Health History Form

Every camper, adult volunteer, and tag must turn in a camp health form. Please complete all 3 pages and return via mail/email/fax with the camp registration. Attach additional information if needed so the staff can better help. No one will be allowed to remain at camp without a completed health form.

Mail the completed registration form to:
Girl Scouts of Central Indiana
Attn: Mandy Montgomery
7201 Girl Scout Ln Indianapolis, IN 46214
or
Email: mmontgomery@girlscoutsindiana.org
Fax: 317.931.3348

General Camp Information

Please provide us with the dates/sessions child will be attending.

Dellwood ______________________ Sycamore Valley ______________________

Na Wa Kwa______________________ STEM Camps ______________________

Journey ______________________

Campers Full Name ______________________________ Age ____ ____ Female ____ Male

Birth date ____/____/____

Home Address ______________________________ ____________ ____ ________
Street City State Zip Code

Primary Emergency Contact Information

Custodial Parent/Guardian ______________________________ Relationship ________________

Home Phone: (____)__________ Work Phone: (____)__________ Other: (____)__________

Emergency Contact Information (other than parent or guardian)

Name ______________________________ Relationship ________________

Home Phone: (____)__________ Work Phone: (____)__________ Other: (____)__________

Home Address ______________________________ ____________ ____ ________
Street City State Zip Code

Additional Emergency Contact Information (if above is unavailable)

Name ______________________________ Relationship ________________

Home Phone: (____)__________ Work Phone: (____)__________ Other: (____)__________

Home Address ______________________________ ____________ ____ ________
Street City State Zip Code

Insurance Information (A copy of the insurance card will need to be provided to camp)

Is the participant covered by medical healthcare insurance? Yes ____ or No ____

If so: Insurance Co. Name __________________________ Policy Number ________________

Name of insured ______________________________ Relationship ________________

Permission to Provide Necessary Treatment or Emergency Care

The information and statements contained within this form are true and correct to the best of my knowledge.
I hereby give permission to GSCI to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to GSCI to provide or arrange necessary related transportation. In the event of an emergency and/or my inability to communicate, I hereby give permission to the physician and/or medical facility selected by the program services director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied.

Signature of parent/guardian ______________________________ Date ____________

Printed Name ______________________________

Health History

Allergies (list all known)

Medication allergies (list) | Describe reaction and management of reaction

______________________ ______________________

______________________ ______________________

______________________ ______________________

Food allergies (list)

______________________ ______________________

______________________ ______________________

______________________ ______________________

Other allergies (list - include insect stings, hay fever, etc.)

______________________ ______________________

______________________ ______________________

______________________ ______________________

Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Medications must be in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

Takes NO medication on a routine basis ______ Takes medications as follows: ______

Med #1 ______________ Dosage ______ Times Taken Daily ______

Reason for ______________________

Med #2 ______________ Dosage ______ Times Taken Daily ______

Reason ______________________

Med #3 ______________ Dosage ______ Times Taken Daily ______

Reason for ______________________

Attach additional page for more information.

Pleae note any medication(s) taken during the year that partcipant does not take during the summer:

____

Non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. Please list any non-prescription medications that should not be given. (use next page for more space)

____

General Questions (explain "yes" answers below)

Question	Y	N
1. Had any recent injury, illness or infection?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury, concussion or been	☐	☐
knocked unconscious?	☐	☐
7. Wear glasses, contacts or protective eye wear?	☐	☐
8. Have frequent ear infections or tubes in their ears?	☐	☐
9. Ever passed out or been dizzy during or after exercise?	☐	☐
10. Ever had seizures, convulsions or epilepsy?	☐	☐
11. Ever had chest pain during or after exercise?	☐	☐
12. Ever had high blood pressure?	☐	☐
13. Ever been diagnosed with a heart murmur?	☐	☐
14. Have frequent sore throats?	☐	☐
15. Have a weight problem (over or under)?	☐	☐
16. Ever tested + for an infectious Disease? (e.g. tuberculosis, hepatitis, etc...)	☐	☐
17. Have a hearing impairment?	☐	☐
18. Have an abnormal menstrual history?	☐	☐
19. Have a history of bedwetting?	☐	☐
20. Ever had an eating disorder?	☐	☐
21. Have cerebral palsy?	☐	☐
22. Ever had emotional difficulties for	☐	☐
which professional help was sought?	☐	☐
23. Have sleeping disorders (e.g. apnea, sleepwalking)?	☐	☐
24. Have any skin problems (e.g. itching, rash, acne)?	☐	☐
25. Ever had problems with back or joints	☐	☐
26. Have a kidney ailment?	☐	☐
27. Use an inhaler or ventilator?	☐	☐
28. Have diabetes?	☐	☐
29. Have asthma or breathing difficulty?	☐	☐
30. Had mononucleosis in the past 12 months?	☐	☐
31. Have problems with diarrhea/constipation?	☐	☐
32. Use assistive devices? (e.g. wheelchair, monitors, prosthetics, etc.)	☐	☐

Please explain any "Yes" answers, noting the number of the question(s).

____

____

Illnesses

Indicate which camper has had.

- Measles
- Chicken Pox/Shingles
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Other ____________________

Immunizations

Please read and sign 1 of the 2 following statements:

1. All immunizations required for school attendance are up to date and my camper's last tetanus shot was (month/year) ______________________________

Signature of parent/guardian ______________________________

Printed name ______________________________

2. My camper has not been fully immunized; I understand and accept the risk to my child from not being fully immunized.

Signature of parent/guardian ______________________________

Printed name ______________________________

Activity Restrictions (i.e., limitations, what cannot be done, what adaptations are necessary)

For anyone with a chronic illness or disability, a written statement from their physician is required and must indicate that the person can participate in routine activities without harm to their self. Routine activities include: hiking at least 1 mile each day, living in a tent with steps, changing own clothes, walking up and down gravel roads, possibly in the dark, with a buddy. Please contact the camp director with any questions.

Unfortunately, we cannot offer one on one helpers.

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

____

____

____

____

____

____