

2018 Health History 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

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.

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 of 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.

Please note any medication(s) taken during the year that participant 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)

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

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

Illnesses

Indicate which campers have 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 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.
