girl scouts of central indiana

Camp Gallahue

Camp Gallahue Health History Form
PLEASE BRING TO CAMP
DO NOT MAIL or FAX EARLY

Do not mail this form.

Parent/guardian may complete. Your child will not be able to remain at camp without a completed health form. **Please bring this form with you to camp on opening day or send it with your daughter on the bus.**

Camper Name _____ Birth date ____/____/____ Age ____
Last First M.I.

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 PRIMARY PARENT OR GUARDIAN)

Name _____ Relationship _____

Home Address _____ _____ _____ _____
Street City State Zip Code

Home Phone: ( ) _____ Work Phone: ( ) _____ Other: ( ) _____

ADDITIONAL EMERGENCY CONTACT INFORMATION, (IF THE ABOVE IS NOT AVAILABLE).

Name _____ Relationship _____

Home Address _____ _____ _____ _____
Street City State Zip Code

Home Phone: ( ) _____ Work Phone: ( ) _____ Other: ( ) _____

INSURANCE INFORMATION (A copy of child's insurance card will need to be provided to Camp Gallahue)

- Is the participant covered by medical healthcare insurance? YES NO
- If so: Insurance Co. Name _____ Policy No. _____

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 Camp Gallahue 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 for trips out of camp.

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.

☐ Child takes NO medication on a routine basis.

☐ Child takes medication as follows:

Med #1 _____ Dosage _____ Times taken daily _____
Reason for taking _____
Med #1 _____ Dosage _____ Times taken daily _____
Reason for taking _____
Med #3 _____ Dosage _____ Times taken daily _____
Reason for taking _____

• Attach additional pages 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.

_____
_____
_____

RESTRICTIONS The following restrictions apply to this individual:

DIETARY RESTRICTIONS (e.g. vegetarian)

☐ Does not eat pork ☐ Does not eat dairy products ☐ Does not eat meat

☐ Other (describe) _____

ACTIVITY RESTRICTIONS (i.e., limitations, what cannot be done, what adaptations are necessary)

_____
_____

For girls with a chronic illness or disability, a written statement from her physician is required and must indicate the girl can participate in routine activities without harm to herself. Routine activities include: hiking at least 2 miles each day, living in a tent with steps, showering and changing clothes by herself, walking up and down sizeable hills, possibly in the dark, with a buddy. If this camper cannot do all of these activities without help, we can suggest other camp opportunities that she might enjoy.

Unfortunately, we cannot offer one on one helpers or rides around camp to our campers.

GENERAL QUESTIONS (Explain "yes" answers below.)

Has your child....

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

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

IMMUNIZATIONS

Please give all dates of immunization or write UP TO DATE

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	
MMR		_____	_____			
	or Measles	_____	_____			
	or Mumps	_____	_____			
	or Rubella	_____	_____			
Haemophilus influenza B		_____	_____	_____		
Hepatitis B		_____	_____	_____		
Varicella (chicken pox)		_____	_____			

If your camper has **not been fully immunized**, please sign the following statement: I understand and accept the risk to my child from not being fully immunized.

Signature of parent/guardian Date _____/_____/____

_____

Printed Name _____

• 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.