

Health History

Please make a copy for your records. To ensure accurate and up-to-date information, we ask that you review your copy and submit a new form (copies of the original are acceptable) at each event attended.



SECTION A					
Health Care Information					
Camper/Adult Participant/Staff/Volunteer Name:					
Address:					
Birth Date:		Age:		Grade Entering in Fall:	
Custodial Care Information – required for participants under the age of 18					
My participant 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 – Name & Relationship:					
Contact Information – required for participants under the age of 18					
Parent/Guardian Name:					
Home Phone:		Work Phone:		Cell:	
Parent/Guardian Name:					
Home Phone:		Work Phone:		Cell:	
Emergency Contact – required for ALL persons; must be different than above, in case parent/guardian contact cannot be reached					
Name:				Relationship:	
Home Phone:		Work Phone:		Cell:	
Address:					
Insurance Information					
Is the participant 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 – required for ALL persons. This information will provide healthcare personnel with the background to provide appropriate care. Any changes should be shared with camp 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)				
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 event/camp session. By completing this information, you are giving permission for event/camp staff or the appointed first aider to administer the medications listed.		Med #1	Med #2	Med #3	Med #4
	Name				
	Dosage				
	Specific times taken each day				
	Reason for taking				
	This participant takes the following medications during the school year which she does not/may not take during the summer:				
Mental/Emotional Health The following mental, emotional, and psychological health information will help our professional event/camp staff prepare and provide the best care for all participants.	This participant has an emotional health concern that will impact their participation. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				
	This participant has had a significant life event that continues to affect their life/health. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:				

General Health Information					
Has/does the participant...	Yes	No	Has/does the participant...	Yes	No
1. Had recent injury, illness/infectious disease?			19. Brought an orthodontic appliance to camp?		
2. Have a chronic or recurring illness/condition?			20. Have any skin problems (itching, rash, etc)?		
3. Ever been hospitalized?			21. Have diabetes?		
4. Ever had surgery?			22. Have asthma?		
5. Have frequent headaches?			23. Had mononucleosis in the past 12 months?		
6. Ever had a head injury?			24. Had problems with diarrhea/constipation?		
7. Ever been knocked unconscious?			25. Have problems with sleepwalking?		
8. Wear glasses, contacts, or protective eye wear?			26. Have an abnormal menstrual history?		
9. Ever had frequent ear infections?			27. Have a history of bedwetting?		
10. Ever passed out during or after exercise?			28. Have an eating disorder?		
11. Ever been dizzy during or after exercise?			29. Has behavioral challenges (ADD, other)?		
12. Ever had seizures?			30. Had measles?		
13. Ever had chest pain during or after exercise?			31. Had mumps?		
14. Ever had high blood pressure?			32. Had chicken pox?		
15. Ever been diagnosed with a heart murmur?			33. Had hepatitis?		
16. Ever had back problems?			34. Had German measles?		
17. Ever had joint problems (knees, ankles, etc)?			35. Had lice, ringworm, or scabies in the past 2 months?		
18. Ever had emotional difficulties for which professional help was sought?					
If you answered yes to any question, please explain, noting question number being referenced.					

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

Doctor Information	
Date of last physical exam (include year):	
Camper’s Physician:	Phone:
Camper’s Dentist/Orthodontist:	Phone:

Special Dietary Restrictions	
The following dietary restrictions apply to this individual.	Does not eat: (circle) red meat pork poultry eggs dairy seafood wheat gluten other:

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

Permission for Basic Medical Treatment

By checking off the following items, I (parent/guardian) hereby give permission for event/camp staff or appointed first aider to administer the marked 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"/> Children’s Pepto-Bismol/Tums/Roloids (upset stomach/diarrhea)	<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"/> Talcum Powder/Baby Powder (skin irritations, heat rash)
<input type="checkbox"/> Sudafed liquid or tablets (stuffy nose)	<input type="checkbox"/> Robitussin DM (cough)
<input type="checkbox"/> Claritin, Claritin D (allergy symptoms)	<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"/> Oatmeal Bath – Aveeno or similar (poison ivy)	<input type="checkbox"/> Epsom Salt (muscle strains, skin irritations)
<input type="checkbox"/> Desitin (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)

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 Participant/Volunteer/Staff)

I hereby give permission to the event/camp staff or appointed first aider 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 event/camp staff 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 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 event/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 event/camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the 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 event/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 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.

Signature of Parent/Guardian/Adult Participant/Volunteer/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 event/camp activities.

Signature of Minor/Adult Participant/Volunteer/Staff: _____ Date: _____



SECTION B: Health Care Recommendation/Physical Examination

*To be complete by a licensed medical professional within 24 months of attendance. Required for all attendees participating in a program lasting 4 or more nights.

I have examined the following person:

Name: _____ Date: _____

BP: _____ Weight: _____ Height: _____

In my opinion, the above applicant IS ABLE NOT ABLE to participate in an active event/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 event/camp:

Treatment to be continued at event/camp:

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

Known allergies:

Description of any limitation or restriction on event/camp activities:

Additional information for health care staff at the event/camp:

Signature of Licensed Medical Personnel: _____

Printed: _____ Title: _____

Address: _____ Phone: _____ Date: _____