2011 CAMPER HEALTH HISTORY for PARENTS/GUARDIANS - PAGE 1

Please return completed forms by May 14th to:
Girl Scouts -- North Carolina Coastal Pines
6901 Pinecrest Rd., Raleigh, NC 27613

Camper Name: ____________________

Date of Birth: __________ Grade on Arrival at Camp: ______

Address: ____________________

City: ____________________

State: __________ Zip Code: ______

Parent / Guardian #1

Name: ____________________

Relationship: ____________________

Email: ____________________

Home Phone: __________ Other: __________

Address: ____________________

City: ____________________

State: __________ Zip Code: ______

Parent / Guardian #2

Name: ____________________

Relationship: ____________________

Home Phone: __________ Other: __________

Emergency Contact in event Parents / Guardians can not be reached:

Name: ____________________

Relationship: ____________________

Home Phone: __________ Other: __________

Health Care Providers

Primary Doctor: __________ Phone: __________

Dentist: __________ Phone: __________

Orthodontist: __________ Phone: __________

Insurance Information

Camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Insurance Company: ____________________

Policy Number: __________ Group/ID Number: __________

Name of Policy Holder: ____________________

Diet / Nutrition

☐ Eats a regular diet ☐ Eats a regular vegetarian diet

☐ Has special food needs (describe below)

____

____

Restrictions

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations

____

____

General Health History

Check "Yes" or "No" for each statement. **Please explain "Yes" answers in the space below**

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent / chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had asthma / wheezing / shortness of breath? ☐ Yes ☐ No
7. Passed out/had chest pain during exercise? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had fainting or dizziness? ☐ Yes ☐ No
10. Had headaches? ☐ Yes ☐ No
11. Had a head injury? ☐ Yes ☐ No
12. Been knocked unconcious? ☐ Yes ☐ No
13. Had frequent ear infections? ☐ Yes ☐ No
14. Had high blood pressure? ☐ Yes ☐ No
15. Have problems with diarrhea / constipation? ☐ Yes ☐ No
16. Have a history of bedwetting? ☐ Yes ☐ No
17. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
18. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
19. Ever had back / joint problems? ☐ Yes ☐ No
20. Have any skin problems? ☐ Yes ☐ No
21. Have diabetes? ☐ Yes ☐ No
22. Had "mono" in the past 12 months? ☐ Yes ☐ No
23. Traveled outside the country in the past 9 months? ☐ Yes ☐ No
24. Have problems with periods / menstruation? ☐ Yes ☐ No
25. Have an orthodontic appliance being brought to camp? ☐ Yes ☐ No

____

____

____

Previous Conditions

Which of the following has the camper had?

☐ Measles ☐ German Measles ☐ Hepatitis A ☐ Hepatitis C

☐ Chicken Pox ☐ Mumps ☐ Hepatitis B

Mental, Emotional, and Social Health

Check "Yes" or "No" for each statement. **Please explain "Yes" answers in the space below**

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? (abuse, death of a loved one, divorce, adoption, foster care, new sibling, survived a disaster) ☐ Yes ☐ No

____

____

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2011 CAMPER HEALTH HISTORY for PARENTS/GUARDIANS - PAGE 2

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6901 Pinecrest Rd., Raleigh, NC 27613

Camper Name: ____________ **Date of Birth:** ____________

Standing Medication Orders The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. My daughter has permission to take or use the following:

☐ Tylenol / Acetaminopen ☐ Tums / Antacid ☐ Pepto Bismol ☐ Sudafed / Decongestant ☐ Other medications as deemed necessary

☐ Benadryl / Antihistamine ☐ Advil / Ibuprofen ☐ Robitussin / Expectorant ☐ Swimmers' Ear / Alcohol Vinegar Solution

Immunization History Provide the month and year for each immunization.

	Dose 1 (Month/Year)	Dose 2 (Month/Year)	Dose 3 (Month/Year)	Dose 4 (Month/Year)	Dose 5 (Month/Year)
Diptheria, tetanus, pertussis (DTaP or TdaP)	____	____	____	____	____
Mumps, measles, rubella (MMR)	____	____			
Polio (IPV)	____	____	____	____	
Haemophilus influenzae type B (HIB)	____	____	____	____	
Pneumococcal (PCV)	____	____	____	____	
Hepatitis B	____	____	____		
Hepatitis A	____	____			
Varicella (Chicken Pox)	____	____	☐ Had Chicken Pox? Date: ____		
Meningococcal meningitis (MCV4)	____				

TB Test Date: ____
☐ Negative ☐ Positive

Tetanus (dT or TdaP) Date: ____

Influenza
Seasonal Date: ____
H1N1 Date: ____

If camper is **NOT** fully immunized, please sign the following statement: I understand and accept the risks to my child from **NOT** being fully immunized.

Printed Name ____ Relationship to Camper ____ Signature ____ Date ____

Parent / Guardian Authorization:
This health history, including prior pages, is correct and accurately reflects the health status of the camper to whom it pertains. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission the camp to arrange necessary related transportation for me/my child. I understand that providing a safe and positive experience to all campers is of utmost importance to the council and that they reserve the right to make decisions of participation based on the extent of the girl's special needs and our ability to meet those needs in the camp setting and other factors as deemed appropriate. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

Printed Name ____ Relationship to Camper ____ Signature ____ Date ____

LICENSED MEDICAL PERSONNEL

Please review this form and complete all remaining sections below

Physical exam must be within last 24 months

Height ____ Weight ____ Blood Pressure ____

Physical exam done today?
☐ Yes ☐ No If "No", date of last physical ____

Diet / Nutrition List dietary restrictions ☐ Eats a regular diet

Medications Include name, dose, frequency ☐ No medications

Restrictions List activity restrictions ☐ No restrictions

Allergies List all allergies and reactions ☐ No known allergies

Past Medical / Surgical History

Physician Authorization: I have reviewed the camper health history form and have discussed the camp program with the camper's parent(s) / guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: ____ City: ____

State: ____ Zip Code: ____ Phone: ____

Name of Licensed Provider ____ Signature ____ Date ____

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MEDICATIONS

Send this confirmation form and your camper's medications with them on the first day of camp.

Name: ______________________________

Date of Birth: ______________________________

Season: ______________________________

Camp Name: ______________________________

Session: ______________________________

Date: ______________________________

PLEASE NOTE THE FOLLOWING:

1. All medications must appear EXACTLY as written on the original medication container. Any discrepancy may result in long delays at drop-off/check-in.
2. All medications MUST be brought to camp in their original container.
3. The original container MUST identify (in English) the name of the medication, concentration, dosage and frequency of administration.
4. Provide enough of each medication to last the entire time the camper will be at camp.
5. Please refrain from sending non-essential over-the-counter medication, vitamins and/or supplements to camp. Over-the-counter pain medications are available in the camp's medical clinic and will be administered by the medical staff on an as needed basis.

Parent / Guardian Authorization:

I have carefully reviewed my child's medications above and certify that this information is accurate.

______________________________ ______________________________

Name of Parent/Guardian Relationship to Camper Signature Date