

Summer Camp 2010

Girl Scouts of Connecticut - Camper ID Card

Camper's Name (last, first)		Phone Number		Camp Attending
Camper's Address		City	Zip Code	Grade Entering
Parent/Guardian		Relationship	Work Number	Camper's Age
Address (if different)			Cell Number	Troop Number (if applicable)
Parent/Guardian		Relationship	Work Number	Bus Stop Location
Address (if different)			Cell Number	◇ This camper will NOT be riding the bus
Persons to notify in emergency if parent can not be reached:				
Name		Relationship	Phone Number	
1				
2				
Persons authorized to pick up child at the bus stop				◇ Family ◇ Troop ◇ Day ◇ Resident ◇ Other (describe)
Name		Relationship	Phone Number	
1				
2				
3				
4				
<i>Persons authorized to pickup child at camp</i>				
Is your child a returning GSOFCT Day Camp camper? ___ No ___ Yes If yes, how many years? _____ Which camps? _____				
It is our goal for your child to have a fun, safe and exciting day camp experience. If there is information that you would like our staff to know to help us help her achieve this goal, please share it here..				
Race/Ethnicity (for statistics only) Please check as applicable. ___ Hispanic or Latino ___ White (Non Hispanic or Latino) ___ Asian ___ Black or African American (Non Hispanic or Latino) ___ Native Hawaiian or Pacific Islander (Non Hispanic or Latino) ___ Native American or Alaska Native (Non Hispanic or Latino) ___ Two or more races (Non Hispanic or Latino)				

Return this form to: *Girl Scouts of Connecticut
 Summer Camp
 20 Washington Avenue
 North Haven, CT 06473*





GIRL SCOUTS OF CONNECTICUT

(800) 922-2770 www.gsofct.org

CONSENT TO PARTICIPATE AND RELEASE

Camper's Name (Please Print) _____ Camp _____

Girl Scouts of Connecticut camps and outdoor program centers frequently have rustic facilities and uneven terrain that may include hills, woodlands, and waterfront areas whose navigation may require concentrated physical exertion (such as walking, hiking, or swimming). Many of the programs/activities described in camp or program literature and provided by Girl Scouts of Connecticut include a variety of rigorous physical activities in the outdoors. By signing this consent for your child to participate, you acknowledge that your child's participation in the program activities, as described in the camp brochure and other materials, requires an acceptance of possible serious injury to your child. You have made your own judgment that your child is capable of participating in activities at camp. You also are representing to Girl Scouts of Connecticut that your child has no undisclosed condition that might affect her fitness or ability to participate with or without reasonable accommodation. Please list below any conditions that might affect your child's ability to participate fully in a particular activity and identify any medical restrictions. We are requesting this information so that we can work with you to determine an appropriate level of participation. Disabilities or medical restrictions will not automatically exclude your child from participating in an activity.

In any program/activity at summer camp, there is always some risk of personal injury or property damage. In return for the agreement to permit your child to participate, you agree that you will not sue Girl Scouts of Connecticut (hereafter the "Council") and its members, employees, agents, assigns, or volunteers for any injury to your child that results from or is aggravated by the inherent risks of your child's participation in a program/activity at summer camp. The inherent risks involved in participation in any program/activity include those injuries which result from circumstances or actions of persons who are not employees or agents of the Council.

Please read this agreement carefully and make certain that you understand it fully before signing it. By signing below you may be giving up substantial rights that belong to you and your child. You agree that you are signing this consent freely and voluntarily.

My child is in good health and does not have any health condition or disability that might affect her ability to participate in:

- | | Yes | No |
|---------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------|
| General activities (All camps) | <input type="checkbox"/> | <input type="checkbox"/> Please initial: _____ |
| Challenge Course and Climbing Wall activities
(Candlewood, Pattagansett, Timber Trails) | <input type="checkbox"/> | <input type="checkbox"/> Please initial: _____ |
| Horseback Riding activities
(Aspetuck, Katoya, Laurel, Timber Trails) | <input type="checkbox"/> | <input type="checkbox"/> Please initial: _____ |

If No, please identify the health condition or disability. Please include such items as allergies, medical restrictions, inability to read directions at an age-appropriate level, or similar factors that employees, agents, assigns, or volunteers of the Council should keep in mind when working with your child.

I certify that I, as parent/guardian with legal responsibility for _____, do consent and agree to her participation in camp programs as described in the camp brochure or other Girl Scout program literature on the terms described above and state that I have completed the form truthfully to the best of my knowledge and ability. I understand that without this form, my camper may not participate in any programs/ activities at summer camp. I agree to instruct my camper to follow all safety instructions given by staff during programs/ activities.

Parent/Guardian's Name (Please print)

Parent/Guardian's Signature

Date Signed

Girl Scouts of Connecticut Behavior Agreement

(This form **must** be signed by **both** Camper & Parent/Guardian and turned in on arrival at camp.)

Girl Scout camp is a community which comes together to help girls live together in the out-of-doors. Girl Scout program helps girls develop *Courage*, Confidence and the integrity of *Character* needed to live cooperatively as positive citizens in our ever changing world. We maintain this focus by following the Girl Scout Law and Promise everyday.

The Girl Scout Promise

On my honor I will try,
To serve God and my country,
To help people at all times,
And to live by the Girl Scout Law

The Girl Scout Law

I will do my best
To be honest and fair,
Friendly and helpful,
Considerate and caring,
Courageous and strong,
And responsible for what I say and do,
And to respect my self and others,
Respect authority,
Use Resources wisely,
Make the world a better place,
And be a sister to every Girl Scout.

Camper Agreement

I _____ agree to follow the Girl Scout Promise and Law while at Girl Scouts of Connecticut Summer Camp and on the bus traveling to and from camp. I will do this by doing my best to be:

- Honest and Fair
- To help where I am needed
- To be friendly and considerate of both fellow Campers and Staff
- To ask for help
- To respect authority
- To use resources wisely
- To protect and improve the world around me
- To show respect for myself and others through my words and actions
- To follow the Girl Scout electronics policy as outlined in the parent handbook**

I understand that if I am unable to follow these rules that my Parents/Guardian will be contacted and I could be sent home from camp at any time by the Camp Director.

Camper Signature _____ Date _____

Parent/Guardian Agreement

I _____ have discussed the above with child and feel that she understands what is to be expected of her while at Girl Scouts of Connecticut Summer Camp. I also understand that should she be unwilling or unable to live within these guidelines, I may be called to pick up my child at her camp. Parents must pick up their child within four hours at day camp, and within 24 hours at resident camp. If a parent fails to collect his/her child within this reasonable amount of time, the child will be reported as abandoned to the local police. I further acknowledge that should my camper be asked to leave due to her behavior there is no refund of tuition.

Parent/ Guardian Signature _____ Date _____



GIRL SCOUTS OF CONNECTICUT

www.gsofct.org 1-800-922-2770

CAMP NAME:
SESSION DATES:

GIRL/STAFF HEALTH RECORD - HEALTH HISTORY

Page 1

- To be completed by parent/guardian or staff member, as applicable.
- This form should provide current information for summer camp.
- If you wish to use this form for other purposes, you should copy it prior to sending it to GSOFACT. GSOFACT maintains forms as required by law, but requires new submission of form annually.

Mail completed health record to:
Girl Scouts of Connecticut
Outdoor Program Department
20 Washington Avenue
North Haven, CT 06473

Participant Information					
Name (Last, First, Initial)		Parent/Guardian		Birth date	Age
Address			City	ST	Zip
Home Phone ()	Work Phone ()	Cell Phone ()			
In Emergency Notify	Relationship to Girl	Cell Phone ()	Home Phone ()	Work Phone ()	

Insurance Information (List your primary policy. This information may be released, if necessary, for insurance purposes.)		
Carrier	ID Number	Group Number
Member Services Phone Number	Address	I accept full responsibility for the costs of any medical care/treatment I have hereby authorized.

Health History (Check all that apply.)		
Diseases	Allergies	Chronic or Recurring Illness
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney	<input type="checkbox"/> Animals <input type="checkbox"/> Food <input type="checkbox"/> Hay Fever <input type="checkbox"/> Insect Stings <input type="checkbox"/> Medicines <input type="checkbox"/> Asthma <input type="checkbox"/> Penicillin	<input type="checkbox"/> Drugs <input type="checkbox"/> Plants <input type="checkbox"/> Pollen <input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures/Convulsions <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Fatigue		
<input type="checkbox"/> Bed Wetting <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Other _____		

My daughter has permission to take or use the following, if available or if provided by me in their original container. During summer camp, over-the-counter medications may only be administered in an emergency when an R.N. is the camp's Director of First Aid and according to the Camp Physician's Standing Orders.

<input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Antibiotic Ointment/Bacitracin/Bactoban <input type="checkbox"/> Antacids <input type="checkbox"/> Calamine/Caladryl <input type="checkbox"/> Wound Wash	<input type="checkbox"/> Benadryl/antihistamine <input type="checkbox"/> Antidiarrheal <input type="checkbox"/> Tums/antacid <input type="checkbox"/> Robitussin/expectorant <input type="checkbox"/> Swimmer's Ear/alcohol-vinegar solution	<input type="checkbox"/> Hydrocortisone Cream <input type="checkbox"/> Hydrogen Peroxide <input type="checkbox"/> Epinephrine <input type="checkbox"/> Advil/ Ibuprofen <input type="checkbox"/> Epi-Pen Jr. (up to 9 years of age) <input type="checkbox"/> Epi-Pen (over 9 years of age)
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Restrictions (The following restrictions apply to this individual.)

Does not eat: Red meat Pork Dairy products Poultry Seafood Eggs Peanuts Other (describe)

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary). Attach explanation, if needed.

General Questions (Please explain any "yes" answers, noting the number of the questions. Attach explanation, if needed.)					
Has/does the participant:	Yes	No	Yes	No	
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have frequent nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have a history of bedwetting?	<input type="checkbox"/>	<input type="checkbox"/>
3. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have any skin problems (e.g., itching, rash)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have severe menstrual cramps?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have an orthodontic appliance being brought to activity?	<input type="checkbox"/>	<input type="checkbox"/>
7. Had an operation or serious injury?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
8. Had a chronic or recurring illness or medical condition?	<input type="checkbox"/>	<input type="checkbox"/>			

Health Information Privacy Statement

The Girl/Staff Health Record is for health care concerns at summer camp only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor during summer camp. Minimal necessary information may be shared with camp staff in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event coordinator by the participant or her legal representative. I have read the above procedures for handling the health form information, and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

This health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me and/or the examining physician. I hereby authorize the Girl Scouts of Connecticut (GSOFACT) and any medical personnel selected by the Camp to provide medical assessment and routine medical treatment/services to my child, including hospitalization, and necessary related transportation, and in case of an emergency, authorize the provision of medically necessary treatment/services, including transfer to a hospital or facility for emergency treatment/services. I release GSOFACT and its officers, directors, employees, personnel, agents, and contractors, from and against any and all claims and liability arising from or related to the provision, authorization and administration of medical treatment, services and medication to my child. My child has not had any serious illness, injury or operation since the day of her last medical examination.

Signature of Parent/Guardian/Staff Member _____ Date _____



GIRL SCOUTS OF CONNECTICUT

www.gsofct.org 1-800-922-2770

GIRL/STAFF HEALTH RECORD - HEALTH EXAMINATION AND IMMUNIZATION P2

<p> ➤ To be filled in by physician after review of health history with parent/guardian/staff member. ➤ This form must be completed within the 24 months preceding a girl's participation in summer camp. ➤ If you wish to use this form for other purposes, you should copy it prior to sending it to GSOFC. GSOFC maintains forms as required by law, but requires new submission of form annually. </p>	<p><i>Mail completed health record to:</i> Girl Scouts of Connecticut Outdoor Program Department 20 Washington Avenue North Haven, CT 06473</p>
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Girl Name (Last, First, Initial)	Date of Examination
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Health Examination (This part is to be filled in by physician after review of health history with parent/guardian.)

Height	Weight	Blood Pressure	Appearance-Nutrition
Eyes: Without Glasses	Left: 20/___	Right: 20/___	With Glasses Left: 20/___ Right: 20/___
Color Vision:			Physician's Comments
Ears: Hearing: Right:		Left:	
Code: Satisfactory: <input checked="" type="checkbox"/> Not Satisfactory: <input checked="" type="checkbox"/> Not Examined: <input checked="" type="checkbox"/>			
Nose	Genitalia		
Throat	Hernia		
Teeth	Skin		Current Treatment (include current medications):
Heart	Musculoskeletal		Explanation of any reported loss of consciousness, convulsion or concussion:
Lungs	Physical/ emotional status		Does the applicant have epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abdomen	Urinalysis*		Does the applicant have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No

* Not required for every health examination. A girl 5-10 should have this test if she has not already had it, either when entering school or at any time since. A girl 11-18 should have this test if she has not had it since entering puberty.

Record of Immunizations

Immunization	Year Primary Series Completed	Year of Last Booster	Immunization	Year Primary Series Completed	Year of Last Booster
DTaP			Oral Polio		
Diphtheria			Measles		
Pertussis (Whooping Cough)			Mumps		
Tetanus			Rubella		
Hep B**			Chicken Pox		
Td***			Meningitis		

Tuberculin test - year last given	Result
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Other _____
 **Effective January 1, 1999, for all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required (105CMR430.155(4)).
 ***Adult tetanus-diphtheria toxoid

When an R.N. is the camp Director of First Aid, I give permission to administer the medication marked below, according to the Camp Physician's Standing Orders.

<input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Antibiotic Ointment/Bacitracin/Bactoban <input type="checkbox"/> Antacids <input type="checkbox"/> Calamine/Caladryl <input type="checkbox"/> Wound Wash	<input type="checkbox"/> Benadryl/antihistamine <input type="checkbox"/> Anti-diarrheal <input type="checkbox"/> Tums/antacid <input type="checkbox"/> Robitussin/expectorant <input type="checkbox"/> Swimmer's Ear/alcohol-vinegar solution	<input type="checkbox"/> Hydrocortisone Cream <input type="checkbox"/> Hydrogen Peroxide <input type="checkbox"/> Epinephrine <input type="checkbox"/> Advil/ Ibuprofen <input type="checkbox"/> Epi-Pen Jr. (up to 9 years of age) <input type="checkbox"/> Epi-Pen (over 9 years of age)
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Physician's Recommendations

Has the applicant been on any medication within the last six (6) months? Yes No If yes, please explain:

For female: Has this person menstruated? Yes No If not, has she told you about it? Yes No If yes, is her menstrual history normal? Yes No

Physician's Recommendations and Restrictions While at Camp

Any treatment to be continued at camp: _____

Any Medications to be administered at camp (specific dosages): _____

Any medically prescribed meal plan or dietary restrictions: _____

Any allergies (food, drug, plants, insects, etc.): _____

Any physical activity to be restricted? _____

Additional health information: _____

This person is in satisfactory condition and may engage in all usual activities, except as noted.

Licensed physician's name	Licensed physician's signature
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City	ST	Zip Code
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Phone _____	Date _____
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If over-the-counter or prescription medications may be taken at summer camp, PLEASE COMPLETE, SIGN, AND ATTACH THE CAMP MEDICATION ADMINISTRATION AUTHORIZATION FORM. INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g., food, medications, environmental).



MEDICATION ADMINISTRATION AUTHORIZATION

for Summer Camp Only

In Connecticut, licensed camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. **Parents/guardians requesting medication administration to their child from camp staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the camper's departure from camp.**

In Massachusetts, all medications are administered in accordance with 105 CMR 430.160.

105 CMR 430.160(A)

Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over-the-counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160(C)

Medication shall only be administered by the health supervisor* or by a licensed health care professional authorized to administer prescription medications. The health care consultant shall acknowledge in writing the list of medications administered at the camp. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.

105 CMR 430.160(D)

When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

**Health Supervisor – A person who is at least 18 years of age, specially trained and certified in at least current American Red Cross First Aid (or its equivalent) and CPR, has been trained in the administration of medications and is under the professional oversight of a licensed health care professional authorized to administer prescription medications.*

Instructions to Parents/Guardians

Page 2 of this Medication Administration Authorization form must be completed and signed by both you and the authorized Prescriber (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse) for EVERY medication – whether over-the-counter (e.g., Advil) or prescription (e.g., Albuterol) – and each medication must have its own form.

Self-Administration Authorization applies to asthma and Epi-Pen medication only.



MEDICATION ADMINISTRATION AUTHORIZATION CAMP

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse) Only one medication per form, please.

Name of Camper _____ Date of Birth ___/___/___ Age ___ Today's Date ___/___/___

Medication Name _____ Controlled Drug? YES NO

Dosage _____ Method _____ Time of Administration/Frequency _____

Specific Instructions for Medication Administration (e.g., on empty stomach, with milk, etc.) _____

_____ Specify Precautions _____

Medication Administration: Start Date ___/___/___ Stop Date ___/___/___ Quantity Received _____

Expiration Date of Medications Received ___/___/___ Special Storage Requirements _____

Relevant Side Effects/Adverse Reactions _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _____

Diagnosis (at parents discretion) _____

Camper may self administer this medication YES NO Prescriber's Initials _____

Prescriber's Name _____ Business Telephone (____) _____

Prescriber's Signature _____ Prescriber's Emergency Telephone (____) _____

Prescriber's Address _____ Town/State/Zip _____

Parent/Guardian Authorization

I hereby authorize that medication be administered to my child as described and directed above and in accordance with CT State Statutes and Regulations and MA 105 CMR 430.160.

Name of Camp where medication administration will occur _____

Camp Program (if applicable) _____ Dates Attending _____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: Mother Father Guardian/Other (explain): _____

Address _____ Town _____ Home Telephone (____) _____

Business Telephone (____) _____ Emergency Telephone (____) _____

Camper may self administer this medication YES NO Parent's Initials _____

Signature of Parent/Guardian _____ Today's Date ___/___/___

Name of Camp Staff Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____