



In accordance with the provisions of 105 CMR 430.000 Minimum Sanitation and Safe Standards for Recreational Camps for Children, Massachusetts State Sanitary Code, Chapter IV.

GIRL SCOUTS OF CONNECTICUT

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

CAMP NAME: <hr/>
SESSION DATES: <hr/>

CAMPER/STAFF HEALTH RECORD - HEALTH HISTORY

- To be completed by parent/guardian or staff member, as applicable.
- This form should provide current information for summer camp.
- Please make a copy of this form for your records 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:
Outdoor Program Department
Girl Scouts of Connecticut
20 Washington Avenue
North Haven, CT 06473

Participant Information					
Name (Last, First, Initial)	Parent/Guardian (Primary Contact)	Birth date	Age at Camp		
Address	City		ST	Zip	
Home Phone	Work Phone	Cell Phone			
In Emergency Notify(Secondary Contact)	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>I accept full responsibility for the costs of any medical care/treatment I have hereby authorized.</i>

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"/> Medicine <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 camper has permission to take or use the following over-the-counter medications at day camp if provided by me in their original container with a Medication Administration Form and/or at resident camp, only when administered by an R.N. on staff and according to the Camp Physician's Standing Orders.

<input type="checkbox"/> Tylenol/Acetaminophen	<input type="checkbox"/> Benadryl /antihistamine	<input type="checkbox"/> Hydrocortisone Cream
<input type="checkbox"/> Advil/ Ibuprofen	<input type="checkbox"/> Antidiarrheal	<input type="checkbox"/> Hydrogen Peroxide
<input type="checkbox"/> Antibiotic Ointment/Bacitracin	<input type="checkbox"/> Robitussin/expectorant	<input type="checkbox"/> Wound Wash
<input type="checkbox"/> Antacids/Tums	<input type="checkbox"/> Swimmer's Ear/alcohol-vinegar solution	<input type="checkbox"/> Calamine/Caladryl

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		
1. Had any recent injury, illness, or infectious disease?	Yes	No	9. Have frequent nosebleeds?	Yes	No
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"/>	16. Have medications to take during/at camp?	<input type="checkbox"/>	<input type="checkbox"/>

Health Information Privacy Statement and Permission to Treat.

The Camper/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 or Staff Member	Date
--	------



In accordance with the provisions of 105 CMR 430.000 Minimum Sanitation and Safe Standards for Recreational Camps for Children, Massachusetts State Sanitary Code, Chapter IV.

www.gsofct.org

1-800-922-2770

CAMP NAME:	_____
SESSION DATES:	_____

CAMPER/STAFF HEALTH RECORD - HEALTH EXAMINATION AND IMMUNIZATION

- **To be filled in by physician** after review of health history with parent/guardian/staff member.
- The health examination must be completed within the 24 months preceding participation in 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 Name (Last, First, Initial)	Date of Examination
---	---------------------

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:	The applicant is under the care of a physician for the following conditions:		
Code: Satisfactory: <input type="checkbox"/> S Not Satisfactory: <input type="checkbox"/> X Not Examined: <input type="checkbox"/> Q			Current Treatment (include current medications):		
Nose	Genitalia		Explanation of any reported loss of consciousness, convulsion or concussion:		
Throat	Hernia		Does the applicant have epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Teeth	Skin		Does the applicant have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart	Musculoskeletal				
Lungs	Physical/ emotional status				
Abdomen	Urinalysis*				

* 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		
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		

Medications taken or needed during camp

At Day Camp – all medications must be provided by the family of the participant accompanied by the completed Medication Administration Authorization Form that is signed by the participant's physician.
At Resident Camp – all prescription medications must be provided by the family of the participant accompanied by the completed Medication Administration Authorization Form that is signed by the participant's physician.
At Resident Camp - over-the-counter medications may be administered by the qualified health staff, following Physician's Standing Orders.

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:
 Any medically prescribed meal plan or dietary restrictions:
 Any allergies (food, drug, plants, insects, animals, 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
---------------------------	--------------------------------

City	ST	Zip Code
------	----	----------

Phone	Date
-------	------