



# Summer Camp Health Exam/History For campers and staff

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.

**Physical exams are valid for 2 years from date of last examination**

Camper                       Staff

**TO BE COMPLETED BY PARENT, GUARDIAN, OR ADULT STAFF**

Camper Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co: \_\_\_\_\_  
ID# \_\_\_\_\_  
Include a copy of the insurance card.

I hereby authorize the Girl Scouts of Connecticut (GSOFC) and any medical personnel selected by the Camp to provide medical assessment and routine medical treatment and 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 GSOFC and its officers, directors, employees, personnel 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.

Signature of Guardian \_\_\_\_\_ Phone \_\_\_\_\_

**TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER**

Date of Exam  
\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ May participate in all camp activities  
\_\_\_\_ May participate except for: \_\_\_\_\_

Does this individual have any current physical, mental or psychological condition(s) requiring medication, treatment, or special restrictions or considerations while at camp?     No                       Yes, Explain: \_\_\_\_\_

Is the individual taking prescription **and/or** over the counter medication(s)?     No                       Yes

If yes, indicate names of medication(s): \_\_\_\_\_

**Reminder!** A Medication Administration Authorization is required for **each** medication.

Has the individual menstruated?     Yes                       No                      If no, does she know about it?     Yes     No

Does the individual have allergies?     No                       Yes, Explain: \_\_\_\_\_

Is this individual on a special diet?     No                       Yes, Explain: \_\_\_\_\_

Does the individual have any other special needs?     No                       Yes, Explain: \_\_\_\_\_

This camper/staff is up to date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

**Date of last Tetanus** \_\_\_\_\_

Signature of Physician, PA, APRN or RN \_\_\_\_\_

Date form signed \_\_\_\_\_

Practitioner's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_