

2012 Farthest North Girl Scout Council Health History & Health Examination Form

PLEASE PRINT

Girl's Name: _____ Birth Date: _____ Age: _____

Mailing Address: _____

Street Address: _____

Parent/Guardian: _____ Phone (wk): _____ (hm): _____

Parent/Guardian: _____ Phone (wk): _____ (hm): _____

Additional Emergency Contact: Name: _____
Phone (wk): _____ Phone (hm): _____

Doctor or Clinic: _____ Phone: _____

Health Plan: _____ Group No.: _____

If Military: Sponsor's Name: _____
Sponsor's Soc. Sec.: _____ Rank: _____ Unit: _____

PARENT AUTHORIZATION:

This health history is correct to the best of my knowledge, and the camper herein described is free of any potential health problems that might restrict participation at camp (except as noted by me and/or the physician) and is free of any communicable diseases that might endanger other campers.

In the event I cannot be reached in an emergency, I hereby give permission for emergency care to be given. This authorization applies whether the charges are covered by Girl Scout insurance or by myself. I give this authorization with knowledge that Girl Scout health insurance is secondary and does not provide coverage for every incident.

PARENT/GUARDIAN'S SIGNATURE

DATE

ALLERGIES:

_____ Hay Fever
_____ Insect Sting
_____ Medicine/Drugs
_____ Plants
_____ Food (Specify)
_____ Pollen
_____ Animals
_____ Other (Specify)

OTHER HEALTH CONDITIONS: (Give approximate dates)

_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps
_____ Asthma
_____ Hepatitis
_____ Rheumatic Fever
_____ Diabetes
_____ Epilepsy
_____ Fainting
_____ Deformities
_____ Limb Brace
_____ Special Shoes
_____ Dental Braces
_____ Glasses
_____ Hearing Aid
_____ Ear Infections
_____ Convulsions
_____ Other (Specify)

Additional Details: _____

Special care you give at home: _____

SPECIAL THINGS YOUR CHILD MAY NEED HELP WITH AT CAMP:

- _____ Behavior problems
- _____ Fear of dark
- _____ Sleepwalking
- _____ Bedwetting
- _____ Recent Operation
- _____ Chronic or Recurring Illness
- _____ Stomach aches & pains
- _____ Growing Pains
- _____ Selective Eater
- _____ Never been away from home alone

IMMUNIZATIONS: (Give dates)

- _____ DPT
- _____ Tetanus Booster
- _____ Oral Polio
- _____ Measles/Rubella
- _____ TB Tine
- _____ Other

Please list any non-prescription medications you DO NOT want your daughter to be administered at camp:

PARENTS, CONTINUE ON REVERSE SIDE

Is there any restriction on physical activity? Explain: _____

Has this camper menstruated? **YES NO** If not, has she been told? _____

If so, is her menstrual history normal? _____ Does she have problems with cramps? _____

List below all medications your camper **will be taking to camp**, including aspirin and cough drops:

WHAT	WHY	INSTRUCTIONS

MEDICAL EXAMINATION –MUST BE FILLED OUT and SIGNED BY DOCTOR, RN, PA, or NP

Camper's Name: _____

Height: _____ Weight: _____ Temperature: _____

Blood Pressure: _____ Pulse: _____

Examination findings – please check box if condition is satisfactory. If not, please explain.

- | | |
|----------------------|---------------|
| _____ Eyes & Vision | _____ Heart |
| _____ Skin | _____ Lungs |
| _____ Throat | _____ Legs |
| _____ Ears & Hearing | _____ Abdomen |

_____ I find this camper in good physical condition for camping, hiking, water sports, competitive sports, and wilderness experiences.

_____ This camper's activities should be limited for the following reasons:

EXAMINER'S SIGNATURE:

ADDRESS: _____

DATE: _____ **PHONE:** _____