girl scouts greater los angeles

Camp Osito Rancho Health History and Medical Examination Form

Please type or write clearly and legibly.

Girl Scouts of Greater Los Angeles Camper Health History Page 1 (Parents/Guardians complete)	*Camper Name:* _____ *First Name* *Middle* *Last* Name of Camp Session:_____ Date of Camp Session:_____ Bus Stop (please check one): ☐ Arcadia ☐ Long Beach ☐ Woodland Hills ☐ Driving to and from camp *Grade:* _____ *Age:*_____
Medication/s must be in original containers and must accompany your camper directly to camp or to camp bus stop. Medication/s should be placed in a large, clear zip-top bag with camper's name clearly labeled. All medicine/s must have dispensing instructions when turned in.	**Parent/Guardian Directions:** • Please read and fill out all pages of the following document. It is your responsibility to communicate all health information for your camper in this form. Additional information about the camp and packing list can be found in the Camp Osito Information Packet. • This Health History Form including the physician's signed report **MUST** be received (or postmarked) at least 2 weeks prior to the first day of your girl's camp session. Please **scan & e-mail** completed form to ositoranchohealthforms@girlscoutsla.org or mail c/o Osito Rancho Health Forms, 4040 N. Bellflower Blvd., Long Beach, Ca 90808. • If your girl is registered for a camp session 2 weeks before the camp start date, her Health History Form must be **scanned & e-mailed** to ositoranchohealthforms@girlscoutsla.org, **by 5:00pm on the Tuesday before** your girl's session of camp. • **We will not be accepting any forms in person the day of your camper's bus departure. If you fail to meet the mentioned deadlines your girl will not be able to attend that session of camp and you will need to contact the registration department for further information regarding the balance of your account.** • For more information regarding the Health History Form, please contact Camp Osito Rancho Hot Line at: 626-677-2282 or email: ositoranchohealthforms@girlscoutsla.org.

Camper Information:

Name of Minor: (Last, First, Middle Initial)	Date of Birth:		
Address:	City:	St:	Zip:

Parent/Guardian with Legal Custody to be contacted in case of illness or injury:

Name:	Relationship: Email:
Preferred Phone numbers: ( ) ( )	Address:

Second Parent/Guardian or other Emergency Contact:

Name:	Relationship: Email:
Preferred Phone numbers: ( ) ( )	Address:

Additional contact in the event parents/guardians can not be reached:

Name:	Relationship: Email:
Preferred Phone numbers: ( ) ( )	Address:

Health Insurance Information (Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)

Policy Holder's Name:	Policy Number:
Insurance Company Name:	Group Number:
Insurance Company Address:	Insurance Company Phone:
Name of Campers Primary doctor(s):	Phone:
Name of Dentist(s):	Phone
Name of Orthodontist(s):	Phone:

Girl Scouts of Greater Los Angeles Camper Health History- Page 2 (Parents/Guardians complete)	*Camper Name:* _____ *First Name* *Middle* *Last* Date of Camp Session:_____ **CAMP OSITO RANCHO**

"Over the Counter" Medication Record

("OTC")

The following non-prescription medications are commonly found in our camp health center and are used on an <u>as needed basis</u> to manage illness and injury. The OTC medicines are administered in addition to any medicines you send with your child.

I, _____, give permission for my daughter,_____, to receive the following "OTC" medication on an "as needed" basis. Unless directed otherwise, medication will be administered as directed by package labeling.

_____

Signature

My child can be given the following (check YES or NO for all that apply):
If you turn in a blank form, NO meds will be administered.

OTC Medication	yes	no	Comments
Acetaminophen-Tylenol or generic (minor aches and pain)			
Alcohol-liquid or wipes			
Aleve			
Aloe Vera Gel/lotion (sunburn, chapped skin)			
Baking soda paste(bites and stings)			
Benadryl-cream/capsule/elixir(stings, bites, colds, allergies)			
Blistex (chapped lips)			
Burn Gel			
Cepacol/Halls/Generic-throat lozenges (sore throat)			
Campho-Phenique(cold/canker sores)			
Caladryl/Calamine lotions			
Dimetapp tablets/elixir(cold/allergies/cough) or non-drowsy			
Dramamine tablets-motions sickness			
Generic eye wash/ sterile saline/visine tears			
Hydrocortisone cream 1/2 or 1% -cortaid (itching)			
Hydrogen Peroxide-antiseptic			
Ibuprofen-advil/motrin/generic(minor aches, pains, cramps)			
Imodium Ad/Pepto-bismol/Kaopectate/generic (diarrhea)			
Insect repellent			
Midol (cramps)			
Milk of Magnesia, Liquid, chewable (constipation)			
Nighttime /Daytime cold formula			
Polysporin/Neosporin/generic antibiotic ointment (scraps, cuts)			
Robitussin Elixir-liquid/gel caps (colds, coughs, allergies)			
2nd skin/mole skin (blisters)			
Sore throat spray- generic (sore throats)			
Squenchers (dehydration)			
Sting Kill /Sting relief/(bites/stings)			
Sudafed-pill/chewable/elixir (colds, allergies			
Sunscreen without Paba			
Tavist-D (allergies)			
Tums/mylanta (indigestion/gas)			
Vaseline (dry skin, problematic nose bleeds)			
Zinc Oxide Ointment (sun block)			

Thank you for your cooperation and help. We appreciate your time to complete this record, as it will help to make your daughters stay at Camp Osito Rancho a healthy and positive experience.

Girl Scouts of Greater Los Angeles Camper Health History- Page 3 (Parents/Guardians complete)	*Camper Name:* _____ *First Name* *Middle* *Last* Date of CampSession:_____ **CAMP OSITO RANCHO**

AUTHORIZATION TO TREAT MINOR

I/We, the undersigned, am/are either or both parents, if both parents have legal custody, or the parent or person having legal custody, or the guardian, of _____, a minor (the "**Minor**"), and do hereby authorize the adult leaders and agents of the Girl Scouts of Greater Los Angeles (collectively the "**Authorized Persons**") to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care for the Minor under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the California Medical Practice Act, and to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care for the Minor by a dentist licensed under the California Dental Practice Act. This authorization is given pursuant to the provisions of Section 6910 of the California Family Code, as amended. Each of the Authorized Persons may exercise the authority granted hereby individually and without the knowledge, consent or joint action of any other of the Authorized Persons. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the Minor, but that any of the above treatment will not be withheld if the undersigned cannot be reached. In no event will Girl Scouts of Greater Los Angeles, its officers, leaders, or agents be held liable for any first aid treatment or hospital care rendered, or drugs, medicine or surgical procedures performed pursuant to this consent. This consent supersedes all prior authorization.

AUTHORIZATION TO TRANSPORT MINOR

I/We hereby give permission for our Girl Scout to ride in a vehicle driven by a licensed adult driver, in a vehicle which has at least minimum liability insurance as required by the State of California, for all off site activities.

This Health History and Medical Examination Form for Minors is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.

Parent/Guardian _____
Print Name

Parent/Guardian _____ Date: _____
Signature

Girl Scouts of Greater Los Angeles Camper Health History- Page4 (Physicians complete)	*Camper Name:* _____ *First Name* *Middle* *Last* Date of Camp Session:_____ **CAMP OSITO RANCHO**

Physician's Signed Report Form

Medical Personnel: Please complete the following sections of this form (pages 4-6). Attach additional information if needed.

Physical exam done today: [ ] Yes [ ]No If "No" date of last physical:_____
(ACA accreditation standards specify physical exam must be within last 12 months of the first day of camp.)

Medical Examination – Must be completed in detail.

Height: _____ Weight: _____ B. P.: _____/_____ Hearing: R ___ L ___
Eyes: With Glasses R 20/_____ L 20/_____ Without Glasses R 20/_____ L 20/_____
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

_____ Nose	_____ Abdomen	_____ Urinalysis*	Other: _____
_____ Throat	_____ Hernia	_____ HGB*	_____
_____ Teeth	_____ Genitalia	_____ Appearance/Nutrition	_____
_____ Heart	_____ Skin	_____ General Physical State	_____
_____ Lungs	_____ Musculoskeletal	_____ General Emotional State	_____

*Girls should have this test if she had not had it since entering puberty.

General Health History. Check all that apply and explain in detail checked answers:

	Arthritis		Had surgery or hospitalized in the last 5 years		Seizures
	Asthma		Sinusitis (Sinus Infections)		Bed Wetting
	Diabetes		Musculoskeletal Disorders		Sleep Disturbances
	Ear Infections		Attention Deficit/Hyperactivity Disorder (ADD/ADHD)		Diarrhea/Constipation
	Has begun menstruation		Emotional – Separation Anxiety		Tuberculosis
	Has problems with period/menstruation		Bleeding Disorder		Kidney Disease
	Heart Defects/Disease		Convulsions/Epilepsy/Seizures		Fainting or Dizziness
	Hypertension		Headaches/Migraines		Back/Joint Problems
	Kidney/Bladder Illness		Eating Disorders (Anorexia, Bulimia, etc.)		Chicken Pox Date:
	Nosebleeds		Mental/Psychological Disorder		Rheumatic Fever
	Skin Problems		Had a recent injury		Has a Recurrent/Chronic Illness
	Traveled outside the U.S. in the last 9 mo.		Had Mononucleosis(Mono) during the past 12 months		Had a recent infectious disease
	Physical Restrictions		Wear Glasses/Contacts		Other:
	Currently under doctor's care for physical, mental, or emotional disorder				

Please explain in detail all checked answers marked above(use additional paper if necessary and attach):

Has camper had a significant life event that continues to affect her today?	**Yes**	**No**
Does camper carry an inhaler?	**Yes**	**No**
Does camper suffer from Anaphylaxis?	**Yes**	**No**
Does camper carry an Epipen?	**Yes**	**No**
Does camper sleepwalk?	**Yes**	**No**

If you answered yes to any of the above, please explain (use additional paper if necessary and attach):

Have you ever had any adverse reactions to general anesthetics? **Yes** **No**
If so, please explain: _____

Girl Scouts of Greater Los Angeles Camper Health History- Page 5 (Physicians complete)	*Camper Name:* _____ *First Name* *Middle* *Last* Date of Session:_____ **CAMP OSITO RANCHO**

Record of Immunization – Must be completed in detail.

	Date Series was Completed	Year of Last Booster
Hepatitis B		
Hepatitia A	_____	_____
Diptheria, Tetanus, Pertussis (DTaP/TdaP)	_____	_____
Tetanus booster (DT/TdaP)	_____	_____
Haemophilus influenza type B (HIB)	_____	_____
Polio (IPV/OPV)	_____	_____
Pneumococcal (PCV)	_____	_____
Mumps, measles,rubella (MMR)	_____	_____
Varicella (chicken pox)		
Meningococcal Memingitis (MCV4)	_____	_____

Other:
Tuberculosis (TB) test:___ date:_____ [ ]negative [ ]positive

Personal and religious beliefs that dictate against immunizations: **Yes** **No** **If yes, please explain:**_____
_____
_____

If your camper <u>has not</u> been fully immunized, please sign the following statement:

I understand and accept the risks to my child from not being fully immunized.
Signature of custodial parent/guardian:_____date:_____relationship to camper_____

Medications:
[ ] This camper will <u>not</u> take any daily medications while attending camp.
[ ] This camper <u>will</u> take the following daily medication(s) while at camp. Please list below:
[ ] This camper <u>will</u> take the following daily vitamins while at camp. Please list below:
"Medications" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. All medications including vitamins must be in its original container with a label and directions on dosage.

List any medications/vitamins she is currently taking (or has taken in the recent past) including dispensing dosage schedule and specific instructions for use.

Medications/Vitamins:	Purpose:	When Given:	Dosage & Specific Instructions for Administering Medications/Vitamins
1.		[ ] Breakfast [ ] Lunch [ ] Dinner [ ] Bedtime [ ] Other	
2.		[ ] Breakfast [ ] Lunch [ ] Dinner [ ] Bedtime [ ] Other	
3.		[ ] Breakfast [ ] Lunch [ ] Dinner [ ] Bedtime [ ] Other	

Diet/Nutrition

Diet, Nutrition: [ ] This camper eats a regular diet.
[ ] This camper has diet restrictions:
[ ] Vegetarian
[ ] Gluten free
[ ] Other explain_____

Girl Scouts of Greater Los Angeles Camper Health History- Page 6 (Physicians complete)	*Camper Name:* _____ *First Name* *Middle* *Last* Date of Camp Session:_____ **CAMP OSITO RANCHO**

Allergies:

This camper is allergic to:

[ ] No known allergies
[ ] Food
[ ] Medicine
[ ] The environment(insects stings, fay fever etc)
[ ] Other

Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Treatment/Therapy

[ ] This camper is not presently under going any treatment
[ ] This camper is undergoing treatment/ therapy at this time for the following conditions
[ ] Treatment/therapy will be continued while at camp (please describe below):

Limitations/Restrictions at Camp

Please provide additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Our High Adventure Program consists of horseback riding, high ropes course, zip line, swimming, canoeing, backpacking, hiking archery.

Does the camper have any limitations or restrictions to any of the activities offered while at camp? Yes No
If you answered 'Yes' to the question above, what do you recommend? (describe below – attach additional information if needed)

Any additional comments/concerns about the health or wellbeing of this camper:

_____
_____
_____
_____
_____

Physician's Information:

I have reviewed the Camper Health History Form and have discussed the camp program with the camper's parents/guardians. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Licensed Physician Name: (Last, First, Middle Initial)	**Phone Number:**		
Address:	**City:**	**St:**	**Zip:**

Signature of Licensed Physician: _____ **State License Number:** _____ **Date:** _____