girl scouts
greater los angeles

DAY CAMP
EMERGENCY HEALTH RECORD

Girl's Name _____ Birth date _____ Age _____

Insurance Carrier _____ Policy # _____ Physician _____

Parent/Guardian _____ Home # (___) _____ Work # (___) _____

Address _____

Email Address: _____

Emergency Contact _____ Home # (___) _____ Work # (___) _____

Address _____ Relation to Girl _____

HEALTH HISTORY (Check those that apply)

- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Diabetes
- ☐ Emotional Disturbances
- ☐ Epilepsy/Seizures
- ☐ Fainting or dizziness
- ☐ Hearing Impairment
- ☐ Headaches/Migraines
- ☐ Motion Sickness
- ☐ Nosebleeds
- ☐ Recent Injury
- ☐ Surgery/Hospitalization (Specify) _____
- ☐ Wears Glasses or Contact Lenses
- ☐ Other (specify)_____

ALLERGIES (Check & Specify)

- ☐ Animals _____
- ☐ Medications _____
- ☐ Food _____
- ☐ Hay Fever
- ☐ Insects (Stings) _____
- ☐ Plants
- ☐ Pollen
- ☐ Other (specify)_____

IMMUNIZATION HISTORY (Information for emergency/medical use only)

VACCINE	DATE EACH DOSE WAS GIVEN					
	1st	2nd	3rd	4th	5th	Booster
POLIO (OPV or IPV)						
DTP/DTaP/DT/Td (Diphtheria, tetanus and/or [acellular] pertussis)						
MMR (Measles, mumps, and rubella)						
HIB						
HEPATITIS B						
VARICELLA (Chickenpox)						
TB SKIN TEST (Most recent)	Date:		Negative / Positive (Circle one)			

☐ Check box if personal and/or religious beliefs dictate against immunization

Is child regularly taking any medication (including inhaler for asthma)? _____ Please list all medication(s) _____

Note: All medication must be in original container, with girl's name, address, dosage, and frequency clearly printed on the label.
Additional health information including disabilities and/or special needs _____

PARENT CONSENT FOR EMERGENCY MEDICAL TREATMENT

The undersigned do hereby authorize the officers, leaders or agents of Girl Scouts of Greater Los Angeles, adult persons into whose care our daughter has been entrusted, to consent to any x-ray examination, anesthetic, medical or surgical treatment and hospital care to be rendered to said minor under the general or special supervision and upon the advice of a physician or surgeon licensed under the provisions of the Medical Practice Act, or to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act.

It is further understood that permission is hereby granted to the officers, leaders or agents of Girl Scouts of Greater Los Angeles to obtain and administer such medical aid or assistance as might, in their judgment, be required for the immediate care of said minor. In the event of such help, the Girl Scouts of Greater Los Angeles, its officers, leaders and agents will not be held liable for any first aid treatment or hospital care rendered, drugs, medicine or surgical procedures performed pursuant to this consent. This consent supersedes all prior authorization.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

If you do not consent to the care or treatment set forth herein, describe in detail what is or is not allowed/permitted. _____