girl scouts
greater los angeles

2015 Skyland Ranch 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)	Dates will attend camp: _____/_____/_____ (Month/Day/Year) to _____/_____/_____ (Month/Day/Year) Camper Name: _____ (First Name / Middle / Last) Birth Date: _____/_____/_____ (Month/Day/Year) Age on arrival at camp _____
This form must be completed and returned to the Long Beach Service Center by June 1st, GSGLA – Long Beach Service Center, c/o Elizabeth Chadwick, 4040 Bellflower Blvd., Long Beach CA 90808	Parents/Guardians: 1. Please complete pages 1, 2 and 3 of this form (Camper Health History). 2. Complete the top of page 4 (Medical Examination) and provide all 4 pages to your child's health care provider for review (pages 1-3) and completion (page 4). 3. After page 4 has been completed and signed by medical personnel, please return to Long Beach Service Center, c/o Elizabeth Chadwick, 4040 Bellflower Blvd, Long Beach 90808.

Camper Information:

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

Parent/Guardian with Legal Custody Information:

Emergency Contact:	Relationship:
Phone:	Alternate Phone:

Second Parent/Guardian or Emergency Contact Information:

Emergency Contact:	Relationship:
Phone:	Alternate Phone:

Emergency Contact Information:

Emergency Contact:	Relationship:
Phone:	Alternate Phone:

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:

Allergies: 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.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Girl Scouts of Greater Los Angeles Camper Health History Page 2 (parents/guardians complete)	Camper Name: _____ First Name Middle Last Birth Date: _____/_____/_____ Month Day Year

Check all that apply and explain in detail checked answers:

☐	Diabetes	☐	Musculoskeletal Disorders	☐	Sleep disturbances
☐	Heart Defects/Disease	☐	Convulsions/Epilepsy/Seizures	☐	Fainting
☐	Asthma	☐	Sinusitis (Sinus Infections)	☐	Bed wetting
☐	Ear Infections	☐	Attention Deficit/Hyperactivity Disorder (ADD/ADHD)	☐	Diarrhea/Constipation
☐	Physical Restrictions	☐	Mental/psychological disorder	☐	Chicken Pox
☐	Kidney/bladder illness	☐	Eating Disorders (Anorexia, Bulimia, etc.)	☐	Measles
☐	Hypertension	☐	Headaches/Migraines	☐	German Measles
☐	Arthritis	☐	Had surgery or hospitalized in the last 5 years	☐	Mumps
☐	Nosebleeds	☐	Currently under doctor's care	☐	Rheumatic Fever
☐	Has begun menstruation	☐	Emotional – Separation Anxiety	☐	Tuberculosis
☐	Menstrual cramps	☐	Bleeding disorder	☐	Kidney Disease
☐	Other:			☐	Back/Joint Problems

Please explain in detail all checked answers marked above:

Does your daughter suffer from Anaphylaxis? Yes No

*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Does your daughter carry an Epipen? Yes No

Does your daughter carry an inhaler? Yes No

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	
4.	

Over-the-Counter Medications: My daughter has permission to take over-the-counter medications in case of accident or injury. Please check all that she has permission to take:

☐	Acetaminophen/Tylenol	☐	Antacid/Tums	☐	Laxatives
☐	Ibuprofen (pain/swelling)	☐	Anti-diarrhea/Imodium	☐	Antibiotic Cream
☐	Benadryl/Antihistamine	☐	Dramamine (motion sickness prevention)	☐	Hydrocortisone Cream
☐	Expectorant/Robitussin	☐	Generic Cough Drops or Sore Throat Spray	☐	Anti-Itch Cream/Calamine Lotions
☐	Decongestant/Sudafed	☐	Lice Shampoo or Cream	☐	Aloe

Special considerations or notes regarding over-the counter medications:

Girl Scouts of Greater Los Angeles Camper Health History Page 3 (parents/guardians complete)	Camper Name: _____ First Name Middle Last Birth Date: _____/_____/_____ Month Day Year

Medications: List any medications she is currently taken (or has taken in the recent past) including dosage schedule and specific instructions for use. Also, please indicate (Yes/No) if minor is allowed to take the medication on her own or if she should be monitored by an advisor. This would include any type of birth control.

Medication	Purpose	When Given (Breakfast, Lunch, Dinner, Bedtime, Other)	Specific Instructions (Amount/Dose/How Given)	Self-Medicate? (Yes/No)
1.				
2.				
3.				
4.				
5.				

Does your child have a Special Medical or Dietary Regiment to be followed? Yes No
If so, please explain: _____

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

Any other information not covered in this form that is important that advisors for this trip know: _____
_____

Record of Immunization – Must be completed in detail. (A copy of camper's immunization records may be attached.)

	Date Series was Completed	Year of Last Booster
Hep B		
DTap/Tdap		
DT/Td		
Hib		
IPV/OPV		
PCV7		
MMR		
Varicella		
Other:		
_____		
_____		
_____		
_____		
_____		

	Date Series was Completed	Year of Last Booster
Typhoid		
Paratyphoid		
Cholera		
Yellow Fever		
Typhus		
Rocky Mountain Spotted Fever		
Tuberculin Test: Year last given		Result _____
Not required immunizations, but recommended		
HPV		
Rota		
MCV4/MPSV4		
Hep A		
TIV/LAIV		

Personal and religious beliefs dictate against immunizations: Yes N

HEALTH INFORMATION PRIVACY STATEMENT

The **Health History and Medical Examination Form for Minors** is for health care concerns at the specified event 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 for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form 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 sponsor, by the participant or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

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.

Signature of Parent/Guardian: _____ **Date:** _____

Girl Scouts of Greater Los Angeles Camper Health History & Medical Exam Page 4 (Physician complete)	Camper Name: _____ First Name Middle Last Birth Date: _____/_____/_____ Month Day Year

Medical Examination – Must be completed in detail.

Physical exam done today? Yes No (If no, date of last physical ____/____/____) Last physical exam must be within last 24 months.
Month Day Year

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.

Allergies

☐	No Known Allergies
☐	Food (list)
☐	Medicine (list)
☐	The Environment (insect stings, hay fever ect.) (list)
☐	Other
Describe previous reactions	

Diet/Nutrition

☐	This camper eats a regular diet	☐	Has a medically prescribed meal plan or dietary restrictions (describe below).
Describe dietary restrictions			

Treatment/Therapy

☐	This camper is undergoing treatment or therapy at this time for the following conditions (describe below)	☐	None
Describe treatment			

Medication

☐	No daily medications	☐	Will take the following prescribed daily medication(s) while at camp (describe below).
(Name, Dose, Frequency)			

Limitations/Restrictions at Camp

Do you feel that the camper will require limitations or restrictions to activity while at camp? Yes No
If you answered 'Yes' to the question above, what do you recommend? (describe below – attach additional information if needed)

Physician Information

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

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

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