girl scouts
greater los angeles

2016 Camp Osito Rancho Health History and Medical Examination Form

Please type or write clearly and legibly.

Most medical and dietary needs can be accommodated however please contact us at ositocamp@girlscoutsla.org discuss any specific requests or concerns prior to attending camp.

Medication/s will be administered by a medical professional at camp and will be kept in the nurse's station. All prescription and OTC 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:

The Camp Osito Rancho Health History Form must be signed by a physician

American Camp Association accreditation standards specify physical exam must be within last 12 months of the first day of camp. ONLY 2016 Camp Osito Rancho Health History Forms will be accepted, no substitutions for school or other camps will be allowed.

Did you….?

- ☐ Complete pages 1-7 of the 2016 Camp Osito Rancho Health History Forms including signatures from a parent/guardian and a physician.
- ☐ **Scan & e-mail all forms** to: ositoranchohealthforms@girlscoutsla.org.
- ☐ **Submit all completed forms at least 2 weeks prior to your camper's session of camp. We will not be accepting any forms in person on the first day of camp.** 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 regarding the balance of your account.

- If forms cannot be emailed or for questions relating to the Health History Form process, please contact the Osito Rancho Health Forms Hotline **at ositoranchohealthforms@girlscoutsla.org or 626-677-2282** for more information.
- Program and packing information will be provided as a link in your email confirmation from registration. Please check that your email is correct when you register to receive vital information on camp. For general questions about programs or operations at Camp Osito Rancho, contact ositocamp@girlscoutsla.org.

Girl Scouts of Greater Los Angeles
Camper Health History

Girl Scouts of Greater Los Angeles
Camper Health History- Page 1
(Parents/Guardians complete)

Please complete and submit pages 1-7 of the following document. It is your responsibility to communicate all health information for your camper in this form.

Camper Name: _____
First Name *Middle* *Last*

Grade** (entering this year):* _____ ***Age:_____ *(sleeping arrangements will be grouped by grade/age)*

Session: ☐ #1 July 12-16, ☐ #2 July 18-23, ☐ #3 July 26-30, ☐ #4 Aug 1-6, ☐ #5 Aug 9-13

Bus Stop (must check one): ☐ Arcadia ☐ Long Beach ☐ Woodland Hills ☐ Driving to and from camp

Serious allergies or food restrictions:

☐ Vegetarian ☐ Dairy Free ☐ Gluten Free ☐ Nut Allergy: _____ ☐ Bee Sting Allergy

☐ Other:

☐ No known allergies or restrictions

Medications to be checked in and out:

☐ inhaler ☐ OTC medications (ie: Benadryl or Tylenol) ☐ Prescription medications ☐ No medications

Total number of medications to be checked in and out:_____

For Office Use Only

*To be filled out by GSGLA only- Please leave blank

Notes to Camp Director:

Girl Scouts of Greater Los Angeles Camper Health History- Page 2 (Parents/Guardians complete)	*Camper Name:* _____ *First Name* *Middle* *Last* ***Grade** (entering this year):* _____ **Age**:_____ **CAMP OSITO RANCHO**

Camper Information:

Name of Minor: (Last, First, Middle Initial)	CIT Camp Name (Only if applicable):		
Date of Birth:	Grade Entering:	Age:	
Address:	City:	St:	Zip:

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

Name:	Relationship:
*Primary Phone number: ( )	*Email:
Secondary Phone number: ( )	Address:

Second Parent/Guardian or other Emergency Contact:

Name:	Relationship:
*Primary Phone number: ( )	*Email:
Secondary Phone number: ( )	Address:

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

Name:	Relationship:
*Primary Phone number: ( )	*Email:
Secondary Phone number: ( )	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:
Name of additional Physician(s) being seen for current treatments: Name of Physician: Field of Treatment: (ie: physical therapist, psychologist, etc.)	Phone:

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

"Over the Counter" Medication Record

("OTC")

The following <u>non-prescription</u> 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 can <u>only</u> be administered with permission as indicated below. All medicines sent with your child will be housed in the camp health center and will be administered by a medical professional when needed in addition to any of the OTC medications indicated below.

I (print your name), _____, give permission for my camper,_____, to receive the following "OTC" medication on an "as needed" basis. Unless instructed otherwise below, 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.

Camper Name: _____
First Name *Middle* *Last*

CAMP OSITO RANCHO

AUTHORIZATION TO TREAT AND TRANSPORT A MINOR

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: _____
Handwritten Signature

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Physician's Signed Report Form

<u>Medical Personnel</u>: Please complete the following sections of this form (pages 5-7). Attach additional information if needed.

Date of Most Recent Physical Examination:

☐ Today's Date:_____ ☐ Previous Date:_____

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
_____

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**
Has camper ever had any adverse reactions to general anesthetics?	**Yes**	**No**

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

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)	_____	_____

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_____

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

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 will be 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	

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):

Diet/Nutrition:

Diet, Nutrition:

☐ **This camper eats a regular diet.**

☐ **This camper has diet restrictions:**

- ☐ **Vegetarian**
- ☐ **Gluten free**
- ☐ **Other (explain):**

Allergies:

This camper is allergic to:

☐ **No known allergies**

☐ **Food (peanuts, shellfish etc)**

☐ **Medicine**

☐ **Environmental (insects stings, hay 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.

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:** _____