

# Health History Form – Girl Scout Council of the Catawba Valley Area

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Recent Photo

**Complete both sides** - This form is for campers/staff and is to be completed by campers/self each year and be signed by parents/guardians for minors. Return this form to GSCCVA, 530 4<sup>th</sup> ST SW, Hickory, NC 28602 at least **two (2) weeks** prior to your session. Campers/Staff will not be admitted to camp without this form on file.

CAMP USE ONLY - Year \_\_\_\_\_  
Session 1 \_\_\_\_\_ Session 2 \_\_\_\_\_

Name \_\_\_\_\_ Female \_\_\_ Male \_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_ Today's Date \_\_\_\_\_  
 Camper \_\_\_ or Staff \_\_\_ Race (Optional): White \_\_\_ Black \_\_\_ Asian \_\_\_ American Indian \_\_\_ Hispanic \_\_\_ Other \_\_\_\_\_  
 Member ID # \_\_\_\_\_ Troop # \_\_\_\_\_ Participant's Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number if different from parent below: (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_  
 1. **Female** Parent/Guardian: \_\_\_\_\_ Cell/Pager: (\_\_\_\_) \_\_\_\_\_  
 Evening Phone: (\_\_\_\_) \_\_\_\_\_ Day Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 2. **Male** Parent/Guardian: \_\_\_\_\_ Cell/Pager: (\_\_\_\_) \_\_\_\_\_  
 Evening Phone: (\_\_\_\_) \_\_\_\_\_ Day Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 3. In case of **emergency**, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Evening Phone: (\_\_\_\_) \_\_\_\_\_ Day Phone: (\_\_\_\_) \_\_\_\_\_ Cell/Pager: (\_\_\_\_) \_\_\_\_\_  
 Name of family physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
 Family medical/hospital insurance carrier: \_\_\_\_\_ Preauthorization Required: Yes \_\_\_ No \_\_\_  
 Name of dentist/orthodontist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Name of other doctor: \_\_\_\_\_ Type: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**General Questions** (Explain "yes" answers below or attach a sheet of paper)

Has/does the participant:	Yes	No	Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?			19. Have an orthodontic appliance being brought to camp?		
2. Have a chronic or recurring illness/condition?			20. Have one of any paired organs (eye, ear, kidney, ovaries)?		
3. Ever been hospitalized? Had surgery?			21. Have any skin problems (e.g. itching, rash, acne)?		
4. Have frequent headaches? nosebleeds?			22. Ever had chest pain during or after exercise?		
5. Have a Hearing Impairment?			23. Ever had a head injury? Been knocked unconscious?		
6. Ever had frequent ear infections?			24. Have problems with sleepwalking?		
7. Had mononucleosis in the past 12 months?			25. Have a history of bed-wetting?		
8. Wear glasses, contacts or protective eye wear?			26. If female, have abnormal menstrual history? Pregnant?		
9. Ever been dizzy or passed out during or after exercise?			27. Uses wheelchair? crutches/cane? prosthesis?		
10. Have asthma/wheezing?			28. Ever had an eating disorder?		
11. Gets motion sickness easily?			29. Had problems with diarrhea/constipation?		
12. Ever had seizures?			30. Has a learning disability? Difficulty reading?		
13. Had head lice in last 12 months (must be free of lice/nits to be admitted into camp)?			31. Has Downs Syndrome? Autism? Cerebral Palsy?		
14. Ever had high blood pressure?			32. Has ADHD or ADD? English is Second Language?		
15. Ever been diagnosed with heart murmur? disease?			33. Has a Speech Impairment? Uses sign language?		
16. Ever had back problems?			34. Ever had emotional difficulties for which professional help was sought?		
17. Have diabetes?			35. Has anyone in your family died before the age of 50?		
18. Ever had problems with joints (e.g. knees, ankles)?			36. Other injuries or illnesses or conditions:		

**Please explain any "yes" answers and note the number** of the questions. Indicate any information useful to the adults in charge in relation to any of these physical or mental health conditions. Also, indicate any activities to be encouraged or restricted, or if participant is currently under care of physician or psychologist.    I've attached a sheet of paper with more information.

Allergies	What	Describe Reaction	Management of Reaction
Medicines/Drugs			
Food			
Other – insect stings, hay fever, latex, animal dander, poison ivy			

1. Which of the following has the participant had? \_\_\_ Chicken Pox \_\_\_ German Measles \_\_\_ Mumps \_\_\_ Hepatitis A \_\_\_ Hepatitis B \_\_\_ Hepatitis C

2. Special dietary regimen (vegetarian – type; religious; allergies; diet, etc.) \_\_\_\_\_

**--Over for Required Parent Signatures and Medication Information--**

Camper/Staff Name \_\_\_\_\_ Year attending camp \_\_\_\_\_ Age at camp \_\_\_\_\_

**3. Swimmer’s eardrops** – To prevent swimmer’s ear, all participants will be given alcohol drops in each ear after swimming. If you do **not approve**, check the following:  Please put the only eardrops the participant brings to camp.  Please no eardrops.

**4. Child’s booster seat** -  Participant is between ages 4 and 8 **and** weights under 80 pounds. Please put in belt-positioning booster seat when riding in a passenger vehicle.

**5. May be given/applied to participant/staff?** (Choose one)

**All** items listed may be given: Acetaminophen, Ibuprofen, Antiseptic Ointment, Calamine/dryl Lotion, Insect Repellent, Kaopectate, Emetrol, Dramamine, Tylenol Cold, Pepto-Bismal (non-fever/flu conditions), Benadryl, and Chloraseptic Spray,  **Other** \_\_\_\_\_.

**Only** the following may be given:  Acetaminophen,  Ibuprofen,  Antiseptic Ointment,  Calamine/dryl Lotion,  Insect Repellent,  Kaopectate,  Emetrol,  Dramamine,  Tylenol Cold,  Pepto-Bismal (non-fever/flu conditions),  Benadryl,  Chloraseptic Spray,  **Other** \_\_\_\_\_.

**6. What current prescription medications is the person on?**

This person **takes NO medications** on a routine basis.

This person **takes medications as follows:**

Name of Medication	Dosage	Frequency	Reason for taking	At Camp?
_____	_____	_____	_____	Yes
_____	_____	_____	_____	Yes
_____	_____	_____	_____	Yes
_____	_____	_____	_____	Yes

Office use	
HS	Staff
___	___
___	___
___	___
___	___

**Parent/Guardian/(Self if age 18 or older) Authorization** (*must be completed in order to attend*): This health history has been completed less than 6 months prior to camp and is correct as far as I know. The person herein described has permission to engage in all prescribed event activities except as noted by me/us and the examining physician. I/We hereby give permission to the camp to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp administration to secure and administer treatment, including hospitalization to order injection and/or surgery, for the person named above. This completed form may be photocopied for trips out of camp. I assume financial responsibility for care and the GSUSA Activity Accident/Sickness Insurance is a secondary insurance.

I will **check** my child before attending each session for any signs of lice and she will be **clear** of lice/nits before checking into camp. It is the Girl Scout Council of the Catawba Valley Area’s policy that we advise the staff about any health concerns regarding the participant, if this is **NOT OK** please check the line:  Council does **NOT** have my/our permission to release information.

The safety of all campers and staff is always the camp’s immediate concern. In some emergency/disaster situations, the camp may experience a lock down or evacuation to a secure site. Therefore, campers are not allowed to leave the camp program unless directed by the Camp Administration or Emergency Services. If the campers/staff need to be picked up by parents in an emergency, the Girl Scout council will notify the parents where and when to pick up their child. I/We understand we **may not** come to camp to pick up our child without prior authorization and trying to do so may get in the way of emergency response/evacuation efforts.

Sole Custody  Joint Custody (Both Parents must sign if there is joint custody of participant or if parents are married)

Mother/Guardian Signature \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

Father/Guardian Signature \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

Participant/Staff if 18 years of age or older \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

To Be Completed by Camp Health Supervisor or Designee		
<b>Unit:</b> MR RB HT RR ML	<b>Person conducting health screening:</b>	<b>Session:</b> Week: 1 2 3 4 5 6
<b>Lice Check:</b> <input type="checkbox"/> OK <input type="checkbox"/> Lice detected, sent home <b>Ear Drops:</b> <input type="checkbox"/> Yes <input type="checkbox"/> Own <input type="checkbox"/> No <b>Booster Seat:</b> <input type="checkbox"/> Yes	<b>Any observable evidence of illness, injury or communicable disease:</b> <input type="checkbox"/> None  <b>Exposure to communicable disease:</b> <input type="checkbox"/> None	<b>Any illness or injury since filled out form:</b> <input type="checkbox"/> None
<b>Restrictions of Activities:</b> <input type="checkbox"/> None	<b>Allergies:</b> <input type="checkbox"/> On Form’s Front <input type="checkbox"/> None	<b>Diet Restrictions:</b> <input type="checkbox"/> None
<b>Medications:</b> <input type="checkbox"/> None <input type="checkbox"/> See medication list above on form.		