Last Name: **First Name:**

Camper:

Name *last* _____ *first* _____

Age _____ Birthdate _____

Parent/Guardian _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ e-mail _____

Home Address _____

City _____ State _____ Zip Code _____

Emergency Contact (other than parent):

Name *last* _____ *first* _____

Day phone ( ) _____ Night phone ( ) _____

Insurance – Is the participant covered by family medical insurance? ☐ yes ☐ no

Insurance Carrier or Plan Name _____

Group # _____

(Photocopy of front and back of health insurance card must be attached to this form.)

Health History (please explain "yes" answers below.)

Has / does the participant:	Yes	No		Yes	No
1. Had an recent injury, illness Infectious disease?	☐	☐	13. Have an orthodontic appliance being brought to camp?	☐	☐
2. Have a chronic or recurring Illness or condition?	☐	☐	14. Have diabetes?	☐	☐
3. Ever been hospitalized?	☐	☐	15. Have asthma?	☐	☐
4. Ever had surgery?	☐	☐	16. Had mononucleosis in the past 12 months?	☐	☐
5. Have frequent headaches?	☐	☐	17. Had problems with diarrhea or constipation?	☐	☐
6. Ever had a head injury?	☐	☐			
7. Ever been unconscious?	☐	☐	18. Sleepwalk?	☐	☐
8. Have frequent ear infections?	☐	☐	19. History of bedwetting?	☐	☐
9. Ever had seizures?	☐	☐	20. Eating disorder?	☐	☐
10. Have high blood pressure?	☐	☐	21. Emotional difficulties?	☐	☐
11. History of nosebleeds?	☐	☐	22. ADD / ADHD?	☐	☐
12. Ever fainted?	☐	☐	23. Motion Sickness?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

Please attach additional pages if needed for further explanation.

Medication Allergies (list)	Describe reaction & management of reaction
_____	_____
_____	_____
_____	_____
_____	_____

Food Allergies (list)	Describe reaction & management of reaction
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies (list)	Describe reaction & management of reaction
_____	_____
_____	_____
_____	_____
_____	_____

Medications Will the camper be bringing any medications to camp? ☐ No ☐ Yes

This person takes medications as follows: (include prescription and over-the-counter)

Med #1 _____ Dosage _____ Times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Times taken each day _____

Reason for taking _____

Please attach additional pages for more medications. Both over-the-counter and prescription meds to be administered at camp must be in the original pharmacy-labeled containers with the patient's name, dosage, time of administration, and any special instructions clearly stated. Please, only one medication per container.

For Females - has she menstruated? ☐ Yes ☐ No

If yes, is her menstrual history normal? _____ If no, does she know about it? _____

Other Special Considerations

_____

_____

_____

Non-Prescription Medication Permission

I hereby grant permission for the Mojave Primitive Encampment to dispense the following over-the-counter medications.

Signature _____ Date _____

Camper's height: _____ Camper's Weight: _____

(Please check all medications that MPE has permission to dispense to your daughter and note any special instructions.)

- ☐ Acetaminophen – generic Tylenol (minor aches and pain) _____
- ☐ Aloe Vera Gel (sunburn) _____
- ☐ Arnica (ointment for muscle soreness/bruising) _____
- ☐ Athlete's Foot Products _____
- ☐ Baking Soda – Paste (bites and stings) _____
- ☐ Benadryl – cream / tablets (stings, bites, colds, allergies) _____
- ☐ Betadine (ointment or solution for cleaning abrasions) _____
- ☐ Calamine Lotion (itching from insect bites) _____
- ☐ Cepacol/Halls/generic – throat lozenges (sore throat) _____
- ☐ Campho-Phenique (cold/canker sores) _____
- ☐ Dacriose/generic eye wash or sterile saline _____
- ☐ Epsom Salt (minor infections) _____
- ☐ Gas relief capsules (for upset stomach / gas) _____
- ☐ Honey (sterile antibacterial - for cut / wound care) _____
- ☐ Hydrocortisone Cream – Cortaid and/or Caladryl (itching) _____
- ☐ Hydrogen Peroxide – antiseptic _____
- ☐ Ibuprofen – generic Advil (minor aches, pain, cramps) _____
- ☐ Imodium AD/generic (diarrhea) _____
- ☐ Insta-Glucose (lowered blood sugar) _____
- ☐ Milk of Magnesia (constipation) _____
- ☐ Mylanta (upset stomach/gas) _____
- ☐ Oragel (toothache) _____
- ☐ Neosporin antibiotic ointment (minor scrapes, cuts) _____
- ☐ Robitussin/generic cough caplets _____
- ☐ Salt, Table (sore throat gargle) _____
- ☐ Sore Throat spray – generic brands (sore throats) _____
- ☐ Triaminic cough / cold strips _____
- ☐ Tums (indigestion, gas) _____
- ☐ Vaseline - night time use only (nosebleeds) _____
- ☐ Vicks Vapor Rub (colds) _____

Please list any dietary concerns:

_____

_____

_____

Immunization History

Please note – Immunization dates must be included on this form. Stating that immunizations are current or up-to-date is not adequate. This information is available from your doctor.

Vaccine: Dates:	M/Yr	M/Yr	M/Yr	M/Yr	M/Yr	M/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Or Measles	_____	_____	_____	_____	_____	_____
Or Mumps	_____	_____	_____	_____	_____	_____
Or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

Parent / Guardian Notification Policy

On rare occasions, due to health or safety concerns, campers are unable to complete the full camp program. If any of the following situations occur, a parent/guardian will be contacted and the appropriate measures will be decided upon.

- ☐ A camper with a fever over 100 degrees
- ☐ A camper who is excessively sick and/or is in the first aid tent for over 12 hours
- ☐ A camper who makes four or more visits to the first aid tent because of an illness
- ☐ A camper who is taken to the emergency room
- ☐ A camper who is a danger to herself and/or to others

Authorization & Permission to Provide Necessary Treatment or Emergency Care:

The undersigned do hereby authorize the officers, leaders or agents of Girl Scouts of Greater Los Angeles, 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 your daughter. In the event of such help, 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.

Signature of Parent / Guardian _____ Date _____