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?	☐	☐
			15. Have asthma?	☐	☐
3. Ever been hospitalized?	☐	☐	16. Had mononucleosis in the past 12 months?	☐	☐
4. Ever had surgery?	☐	☐			
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 These are what are stocked by MPE in-town & desert.)

- ☐ Acetaminophen – generic Tylenol (minor aches and pain) ______________________________
- ☐ Aloe Vera Gel (sunburn) ______________________________
- ☐ Athlete's Foot Products ______________________________
- ☐ Baking Soda – Paste (bites and stings) ______________________________
- ☐ Benadryl – cream / tablets (stings, bites, colds, allergies) ______________________________
- ☐ Calamine Lotion (itching from insect bites) ______________________________
- ☐ Cepacol/Halls/generic – throat lozenges (sore throat) ______________________________
- ☐ Epsom Salt (minor infections) ______________________________
- ☐ Gas relief capsules (for upset stomach / gas) ______________________________
- ☐ Hydrocortisone Cream – Cortaid generic (itching) ______________________________
- ☐ Hydrogen Peroxide – cleaning wounds / antiseptic ______________________________
- ☐ Ibuprofen – generic Advil (minor aches, pain, cramps) ______________________________
- ☐ Imodium AD/generic (diarrhea) ______________________________
- ☐ Insta-Glucose (lowered blood sugar) ______________________________
- ☐ Mucus Relief Liquid (generic Mucinex) ______________________________
- ☐ Oragel (toothache) ______________________________
- ☐ Neosporin antibiotic ointment (minor scrapes, cuts) ______________________________
- ☐ Robitussin/generic cough liquid / caplets ______________________________
- ☐ Salt, Table (sore throat gargle) ______________________________
- ☐ Sore Throat spray – generic brands (sore throats) ______________________________
- ☐ Sterile saline eye wash (sand in eyes, etc.) ______________________________
- ☐ Triaminic/generic cold liquid ______________________________
- ☐ Tums (indigestion, gas) ______________________________
- ☐ Vaseline (nosebleeds) ______________________________
- ☐ Vicks Vapor Rub (colds) ______________________________

Please list any dietary concerns:

____

____

____

Immunization History

Please note – Immunization dates must be included. Stating that immunizations are "up-to-date" is not adequate. This information is available from your doctor. ***Current tetanus is required****.*

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 __________