

Last Name: _____	First Name: _____
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Nickname (if any): _____

Age _____ Birth date _____

Parent/Guardian _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____ e-mail _____

Home Address _____

City _____ State _____ Zip Code _____

Health Insurance –

Is the participant covered by family medical insurance? yes no

Insurance Carrier or Plan Name _____

Group # _____

Health History (please explain “yes” answers below.)

- | Has / does the participant: | Yes | No | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|
| 1. Had a recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have diabetes? | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness or condition? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have asthma? | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Problem with stomach, diarrhea, or constipation? | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Sleepwalk? | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 16. History of bedwetting? | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Eating disorder? | <input type="checkbox"/> |
| 7. Ever been unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Emotional difficulties? | <input type="checkbox"/> |
| 8. Frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Attention issues? | <input type="checkbox"/> |
| 9. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Anxiety issues? | <input type="checkbox"/> |
| 10. Have high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Knee/hip/back or other joint/bone issues? | <input type="checkbox"/> |
| 11. History of nosebleeds? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Anything else? | <input type="checkbox"/> |

Health History, continued:

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 medications to camp? No Yes

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

Med #1 _____ Dosage/times per day: _____

Reason for taking _____

Med #2 _____ Dosage/times per 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 Campers - has she menstruated? Yes No

If she has not begun menstruating, does she know about it? _____

Please List Any Other Special Considerations or Concerns:

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 taken.

- A camper with a fever over 100 degrees
- A camper who comes down with a communicable disease
- A camper who is excessively sick with a condition or illness that we cannot manage at camp
- A camper who is taken to urgent care or the emergency room
- A camper who is a danger to herself and/or to others

Non-Prescription Medication Permission

I hereby grant permission to dispense the following over-the-counter medications.

Parent Signature _____ Date _____

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

Please check all medications that we have permission to dispense to your daughter and note any special instructions. We calculate dosage by weight so please be accurate with your daughter's information.

- Acetaminophen – generic Tylenol (aches and pain) _____
- Aloe Vera Gel (sunburn) _____
- Benadryl – cream / tablets (stings, bites, allergies) _____
- Celox / Bleed Cease (for stopping serious nosebleeds) _____
- Hydrocortisone Cream – Cortaid generic (itching) _____
- Hydrogen Peroxide – cleaning wounds / antiseptic _____
- Ibuprofen – generic Advil (minor aches, pain, cramps) _____
- Imodium AD/generic (diarrhea) _____
- Ocean Nasal Mist (saline, for nosebleeds) _____
- Neosporin antibiotic ointment (minor scrapes, cuts) _____
- Sterile saline eye wash (sand in eyes, etc.) _____
- Vaseline (nosebleeds) _____

Please list any medication or dietary concerns:

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 _____