

GIRL SCOUTS OF MIDDLE TENNESSEE CAMPER HEALTH HISTORY FORM

To be filled out by parent/guardian then reviewed & signed by doctor or nurse practitioner.
A copy -- front & back -- of camper's health insurance card must accompany this form.

Camper's Name (First, Middle, Last)		Parent/Guardian Full Name		Phone
Address	City	State	Zip	Camper's Birth Date
Emergency Contact	Relationship to Camper		Phone 1	Phone 2

HEALTH HISTORY -- check all that apply to camper

AS NEEDED MEDICATIONS

<input type="checkbox"/> Fainting/dizzy spells <input type="checkbox"/> Bedwetting How often _____ <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Constipation/Diarrhea <input type="checkbox"/> Menstruation cramps/irregularities <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Phobias <input type="checkbox"/> Sinusitis <input type="checkbox"/> Sore throats	<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart problems <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Asthma/Respiratory problems <input type="checkbox"/> Ear infections <input type="checkbox"/> Seizures <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Eating disorder <input type="checkbox"/> Emotional/Social disorders* *Explain in attached document	Camp Health Care Supervisor may administer the following to the camper on an as-needed basis: <input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Advil/Ibuprofen <input type="checkbox"/> Sudafed/Decongestant <input type="checkbox"/> Benadryl/Antihistamine <input type="checkbox"/> Robitussin/Expectorant <input type="checkbox"/> Pepto Bismol <input type="checkbox"/> Tums/Antacid <input type="checkbox"/> Calamine Lotion <input type="checkbox"/> Antibiotic Cream <input type="checkbox"/> Swimmer's Ear Solution
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Explain all items checked above:

Allergies No known Allergies
 Allergic to: Food Medicine Environment (insect stings, hay fever, etc) Other
 Please explain reactions:

Diet/Nutrition Eats a regular diet Eats a regular vegetarian diet Has special dietary needs
 Please explain.

Significant Life Events. Please explain how this may affect camper's experience while at camp.

PARENT/GUARDIAN AUTHORIZATION FOR HEALTHCARE

The camper described on this form has permission to participate in all camp activities, except as noted by me and/or her doctor. I give permission to the doctor selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If the contact listed above cannot be reached in case of an emergency, I give my permission to the doctor to hospitalize, secure proper treatment, and order injection, anesthesia, or surgery for this camper. I understand the information on this form may be shared with camp staff on a need to know basis. I give permission to copy this form. Camp has permission to obtain my child's health records from health care providers and discuss her health status with them.

Parent/Guardian Name: _____
Print
Signature
Date

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Dates Attending _____ **Camper's Name** _____

The camper's doctor or nurse practitioner must fill out designated areas and sign.
Girl Scout program standards require a physical exam within 24 months of attending camp.

Date of last physical examination _____ (mo/day/yr)

IMMUNIZATION HISTORY Copies of immunization records may be attached.

Immunization	Date Primary Series Completed	Date of Last booster
DTaP (diphtheria, tetanus, pertussis)	_____	_____
dT or TdaP (tetanus booster)	_____	_____
MMR (mumps, measles, rubella)	_____	_____
Hepatitis B	_____	_____
TB (tuberculosis)	_____	_____ result of TB test
IPV (polio)	_____	_____
HIB (haemophilus influenza type B)	_____	_____

MEDICATION

This camper will not take daily medications while attending camp _____ Initial & Date

This camper will take the following medication(s) while at camp _____ Initial & Date

Medication Name	Reason for taking	Time Given	Dose Given	How Given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime		

HEALTH CARE PROFESSIONAL INFORMATION

Do you feel this camper will require restrictions while at camp? No Yes

Please provide instructions on limitations and restrictions and attach to this document.

"I have reviewed this camper's Health History Form and discussed with her parent/guardian the camper's participation in the activities and environment that camp entails. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program, except as noted in limitations and restrictions attached."

Doctor/Nurse Practitioner: _____
Print Signature Date

Office Address: _____ Telephone _____