girl scouts of middle tennessee

2021 Summer Camp
Staff Health History Form

Girl Scouts of Middle Tennessee | 4522 Granny White Pike, Nashville TN 37204
Phone/Fax: (615) 460-0212 | **gsmidtn.org**

Staff Information

Staff Name: ____________________

Staff Date of Birth: ______ / ______ / ________ Phone: (______) ________________

Address (Street, Apt. #): ____________________ City: ____________ State: ______ Zip: ________

Name of Camp *(check all that apply)*: ______ Camp Holloway ______ Camp Sycamore Hills

Emergency Contact Information

Emergency Contact #1 Name: ____________________ Relationship: ____________

Email: ____________________

Preferred Phone: (______) ________________ Secondary Phone: (______) ________________

Emergency Contact #2 Name: ____________________ Relationship: ____________

Email: ____________________

Preferred Phone: (______) ________________ Secondary Phone: (______) ________________

Emergency Contact #3 Name: ____________________ Relationship: ____________

Email: ____________________

Preferred Phone: (______) ________________ Secondary Phone: (______) ________________

Authorization for Healthcare

If the contacts listed above cannot be reached in case of an emergency, I give my permission to the doctor to hospitalize, secure proper treatment, order injection, anesthesia, or surgery for me. I understand the information on this form may be shared with the camp director or other designated staff on a need-to-know basis. I give permission to copy this form.

Staff Name: ____________________

Staff Signature *(if staff is over 18)*: ____________________ Date: ____________

Parent/Guardian Signature *(if staff is under 18)*: ____________________ Date: ____________

Authorization for COVID-19

I agree to be tested for COVID-19 or any other infection at the request of Girl Scouts of Middle Tennessee. If I am tested outside of a test requested by Girl Scouts of Middle Tennessee, I agree to share the results with Girl Scouts of Middle Tennessee and to follow doctor's recommendations based on the result.

Staff Name: ____________________

Staff Signature *(if staff is over 18)*: ____________________ Date: ____________

Parent/Guardian Signature *(if staff is under 18)*: ____________________ Date: ____________

Insurance Information *(Please attach a copy of your insurance card.)*

Insurance Company: ________________ Policy #: ________________ Group #: ____________

Insurance Address: ________________ City: ____________ State: ______ Zip: ________

Name of Insured: ____________________ Relationship: ____________

Insurance Phone: (______) ________________

2021 Summer Camp
Staff Health History Form

Girl Scouts of Middle Tennessee | 4522 Granny White Pike, Nashville TN 37204
Phone: (615) 460-0212 | **Fax:** (615) 460-0238 | **gsmidtn.org**

Staff Name: ______________________ Staff Height: __________ Staff Weight: __________

Health History Information *(Please check all that apply.)*

HEALTH HISTORY *(This information will be shared with healthcare staff and camp director on a need-to-know basis.)*

- ______ Asthma/Respiratory Problems
- ______ Bleeding Disorders
- ______ Cardiac History
- ______ Constipation/Diarrhea
- ______ Dermatological History
- ______ Diabetes
- ______ Ear Infections
- ______ Eating Disorder
- ______ Fainting/Dizzy Spells
- ______ Headaches/Migraines
- ______ High/Low Blood Pressure
- ______ Menstruation Cramps/Irregularities
- ______ Nosebleeds
- ______ Phobias *(type: ______________________)*
- ______ Seizures
- ______ Sinusitis
- ______ Sleep Disturbances
- ______ Sore Throats
- ______ Surgeries *(type: ______________________ date: ______________)*

Please explain all items checked in Health History column:

Parent/Guardian Signature *(if staff is under 18)*: ______________________ Date: ______________

Allergy Information *(Please check all that apply to you.)*

☐ I have no known allergies.

I am allergic to: ☐ Food ☐ Medicine ☐ Environment (insect stings, hay fever, etc.) ☐ Latex ☐ Other

Are any of these allergies anaphylactic? ☐ Yes ☐ No **Will you have an EpiPen at camp?** ☐ Yes ☐ No

Please explain allergies and/or reactions:

Diet/Nutrition Information

Aside from allergies included in this form, I *(check all that apply)*:

☐ am a picky eater ☐ am vegetarian ☐ am vegan ☐ eat a kosher diet ☐ do not eat gluten ☐ do not eat dairy ☐ have other dietary needs

Please explain:

girl scouts of middle tennessee

2021 Summer Camp
Staff Health History Form

Girl Scouts of Middle Tennessee | 4522 Granny White Pike, Nashville TN 37204
Phone: (615) 460-0212 | **Fax:** (615) 460-0238 | **gsmidtn.org**

Immunization History *(Copies of immunization records may be attached.)*

IMMUNIZATION	DATE OF PRIMARY SERIES COMPLETED	DATE OF LAST BOOSTER
Hib *(hemophilus influenza type B)*		
Pneumococcal Conjugate Vaccine *(PCV)*		
DTP, DTap, DT, Td *(diphtheria, tetanus, pertussis)*		
IPV or **OPV Poliomyelitis** *(polio)*		
Hepatitis B		
Hepatitis A		
Measles		
Mumps		
Rubella		
Varicella		
Meningococcal		
COVID-19 *(please provide documentation)*		

Medication Taken Regularly at Camp *(Check one and fill in all required information.)*

Please note that all medication must remain locked in the health office with exceptions made for inhalers, EpiPens, etc.

☐ I will **NOT** take any daily medications while attending camp. Initial: ______ Date: ______

☐ I will take the following daily medications while attending camp. Initial: ______ Date: ______

Medication #1: ______ Reason: ______

Dosage: ______ Times to be given: ______

Medication #2: ______ Reason: ______

Dosage: ______ Times to be given: ______

Medication #3: ______ Reason: ______

Dosage: ______ Times to be given: ______

Medication #4: ______ Reason: ______

Dosage: ______ Times to be given: ______

Allergies: ______

Authorization for Medication

All prescription medication brought to camp must be in the original pharmacy-labeled container that displays your name, prescription number, medication name and dosage, administration instructions, date, licensed prescriber's name, and pharmacy name, address and phone number, and must be taken according to the directions on the label. If the doctor has changed the dosage or directions for administration, submit a signed letter from your physician with the new directions. The letter must include your full name, dosage amount, delivery time(s), and any limitations.

All medication brought to camp must be in its original packaging and be stored in the health office. Staff over the age of 18 are responsible for administering their own medication according to prescriptions or packaging directions. Staff under the age of 18 will receive medication from the health officer.

DO NOT repackage medication or bring another person's medication (this is prohibited by law).

I have read and understand these conditions. I have given proper information to the best of my ability.

Staff Name: ______

Staff Signature *(if staff is over 18)*: ______ Date: ______

Parent/Guardian Signature *(if staff is under 18)*: ______ Date: ______