

Staff Information

Staff Name: _____
Staff Date of Birth: _____ Phone: _____
Mailing 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: _____

Staff Name: _____

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.)

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Asthma/Respiratory Problems | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Menstruation Cramps/Irregularities |
| <input type="checkbox"/> Cardiac History | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Phobias (type: _____) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dermatological History | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sore Throats |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Surgeries (type: _____) |
| <input type="checkbox"/> Fainting/Dizzy Spells | date: _____) |

Please explain all items checked in Health History column: _____

Any other health conditions or concerns we should be aware of? _____

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

If yes, what type of exposure triggers a reaction? (Airborne particles, contact, ingestion, etc.) _____

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

have a diet which follows religious guidelines do not eat gluten do not eat dairy have other dietary needs

Please explain: _____

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

IMMUNIZATION	DATE OF LAST RECEIVED	DATE OF LAST BOOSTER
DTP, DTap, DT, Td (diphtheria, tetanus, pertussis)		
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: _____