Girl Scouts

Camper Health History Record with Physical

DUE May 15, 2022

PARENT: *Complete form INCLUDING Part VII – Parent Signature section on the back*
PHYSICIAN: *Complete Part VIII Record of Health Examination on back of form*

Mail signed & completed form to: *Two Sentinels Girl Scout Camp. PO Box 10906 Pleasanton, CA 94588.* **-or-** *scan & upload to Ultracamp*

PART I: CAMPER RECORD

Camper's Name - Last, First, Middle Initial | Birth Date - MM/DD/YYYY | Age

Home Address | City/State/Zip

Parent/Guardian Name | Day Time Telephone ( ) | Evening Phone ( ) | Cell Phone ( )

Parent/Guardian Name | Day Time Telephone ( ) | Evening Phone ( ) | Cell Phone ( )

PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name | Day Time Telephone ( ) | Evening Phone ( )

Home Address | City/State/Zip | Relationship to Camper

PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN:_____ Telephone: ( )_____

Address of family PHYSICIAN:_____ City / State / Zip_____

Family Medical/Hospital INSURANCE CARRIER: _____ POLICY/GROUP NUMBER: _____

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.? ❒ Yes ❒ No

If yes, what ID number does your child use? What is the HMO main phone number for emergencies? ( )

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) **❒ Check here for no known allergies**

❒ Animals_____ ❒ Hay Fever _____ ❒ Medicines/Drugs _____
❒ Pollen _____ ❒ Food_____ ❒ Insect Stings _____
❒ Plants/Poison Oak _____ ❒ Other (specify) _____

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

❒ Asthma _____ ❒ Diabetes_____ ❒ Heart Defect/Disease _____
❒ Musculoskeletal Disorder _____ ❒ Bleeding/Clotting Disorders _____ ❒ Ear Infection _____
❒ Hypertension _____ ❒ Seizures/Convulsions _____ ❒ Mononucleosis _____
❒ Skin Disease/MRSA _____ ❒ Other (specify) _____

Childhood Diseases: (Check those that apply and give appropriate dates)

❒ Chicken Pox _____ ❒ Measles _____ ❒ German Measles _____
❒ Mumps _____ ❒ Other (specify) _____

Other Health Conditions: (Check those that apply)

❒Attention Deficit Disorder (ADD) ❒Down's Syndrome ❒Hearing Impairment ❒Nose Bleeds
❒Wears Glasses/Contacts ❒Bed Wetting ❒Emotional Disturbances ❒Menstrual Cramps
❒Sickle Cell Trait/Disease ❒Special Dietary Regimen ❒Dental Braces ❒Fainting
❒Motion Sickness ❒Sleep Disturbances ❒Visual Impairment

List any current physical, mental or psychological health conditions requiring medical treatment, special restrictions or considerations: ____

_____

List any dietary restrictions or special considerations (PLEASE NOTE: TWO SENTINELS IS NOT A NUT-FREE FACILITY!): _____

_____

List any previous medical treatments, operations or serious injuries, provide dates: _____

_____

PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you **DO NOT** want your daughter to receive: _____

Is your daughter taking any medications? ❒ NO ❒ YES

If YES, list medication, dosage, and possible side effects.

MEDICATION DOSAGE POSSIBLE SIDE EFFECTS

_____

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the child's name, address, dosage and frequency. Please label with name and dosage any over-the-counter drugs - antihistamines, vitamins, etc.

PART VI: IMMUNIZATION HISTORY – REQUIRED I am attaching a list of all medical immunizations with the health history form OR I attest that all immunizations for school are current (please initial) _____

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria, Tetanus, and Pertussis; DTP, DTaP or any combination of DTP or DTap with DT (tetanus and diphtheria)		
Tdap Booster		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles, Mumps, Rubella (MMR)		
Hepatitis B		
Tuberculin test given _____(most recent)		
Varicella		

Have you had the COVID-19 vaccine? (This does not impact participation) Yes____ No____ Both doses? Y____ N___ Booster? Y___ N___

List any condition that would limit full activity and in what way: _____

_____

Additional comments from parents/guardians: _____

_____

PART VII: PARENT CONSENT

This health history is correct as far as I know, and my child has permission to engage in all prescribed activities, except as noted by me and the physician. My child is in good health. I give permission for my child to receive treatment for routine medical and/or first aid needs, as outlined in the Treatment Protocols, and for the administration of prescribed medications. In the event I cannot be reached in an emergency, I give my permission for my child_____to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action. I understand that Two Sentinels is NOT a nut-free facility. **THIS FORM IS DUE May 15, 2022**

*All medications being taken are listed on the front of this form.

_____

_____

Signature of Parent/Guardian **Date**

PART VIII: RECORD OF HEALTH EXAMINATION

To be completed within 12 months of camp attendance by a LICENSED PHYSICIAN – MD, PHYSICIAN'S ASSISTANT OR A NURSE PRACTITIONER ACTING UNDER THE SUPERVISION OF A LICENSED MD

Dear Provider-our camp is located at an elevation of 8000 feet. Activities may include hiking with a pack, and other high-adventure activities. Please assess this camper for any pre-existing conditions, (e.g., ankle, knee, head injuries) that may affect their ability to participate in these activities.

I have examined the above applicant within the past 12 months. DATE EXAMINED _____

In my opinion, the above applicant's condition ____ IS _____ IS NOT suitable for active participation in this high-altitude program. Activities to be limited _____

The applicant is under the care of a physician for the following conditions: _____

_____

Current treatment (including medications): _____

_____

_____

Height_____ Weight _____ Blood Pressure_____

Name of Physician _____

Signature of Physician _____

Phone (_____) _____

Date Signed _____

Doctor's Office Stamp or Address