



Staff Health History Record with Physical

DUE May 15, 2022

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

STAFF MEMBER: Complete form through Part VII – Signature section on the back.
PHYSICIAN: Complete statement on back of form.

STAFF TS CAMP NAME: _____

PART I: STAFF RECORD

Name - Last, First, Middle Initial _____ Birth Date - MM/DD/YYYY _____ Age _____

Home Address _____ City/State/Zip _____

Day Time Telephone () _____ Evening Phone () _____ Cell Phone () _____

PART II: EMERGENCY CONTACT

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

Home Address _____ City/State/Zip _____ Relationship to Staff _____

PART III: HEALTH INSURANCE INFORMATION

Name of PHYSICIAN: _____ Telephone: () _____

Address of 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 do you 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 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 to receive: _____

Do you take any medications? (Rx or Over the Counter OTC)
 NO YES
 If YES, do you require any medication that might impair your ability to perform the essential functions of your position? This information must be disclosed and discussed with the Health Staff.
 NO YES
Note: Medications (both Rx and OTC) must be turned in after your arrival and will be locked in the Health Center. Health Staff are available during regular hours and you can access your medications there during those posted times.

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the 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 attest that all immunizations are current (please initial) _____

Vaccines		Year of Basic Immunization	Year of Last Booster
DPT	Diphtheria, Pertussis (Whooping Cough), Tetanus		
TD	Tetanus, Diphtheria		
Tetanus			
Oral Polio (Sabin)* TOPV			
Injectable Polio (Salk)			
Measles (hard measles, red measles, Rubeola)			
Rubella (German measles, 3-day measles)			
Tuberculin test given _____ (most recent)			
Hepatitis B			
Other:			

Have you had the COVID-19 vaccine? (This does not impact participation!) Yes ___ No ___ Both doses? Y ___ N ___

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

Additional comments: _____

PART VII: CONSENT

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the physician. I am in good health. I give permission for 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 am unable to give verbal consent, I give my permission to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact 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 Adult Staff Member (or parent if Staff is younger than 18 years of age)

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

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 his/her participation in an active 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