

Staff Camp Name _____

**GIRL SCOUTS OF NORTHERN CALIFORNIA
TWO SENTINELS GIRL SCOUT CAMP
2012 ADULT HEALTH RECORD**

CAMP **TWO SENTINELS**

POSITION **VOLUNTEER STAFF**

NAME _____ BIRTHDATE ____/____/____ SEX _____

ADDRESS _____ PHONE (____) _____
Number Street City State Zip

IN EMERGENCY, NOTIFY (NAME) _____ RELATIONSHIP _____

ADDRESS _____ PHONE (____) _____
Number Street City State Zip

I am covered by health insurance (other than Girl Scouts): Yes _____ No _____

If Yes, Company: _____

Policy No: _____ Coverage Code or ID No: _____

Name of Subscriber: _____ Birthdate of Subscriber: _____

- Adults must have the signed documentation from a licensed physician (SEE REVERSE SIDE OF THIS FORM) to participate in camp program.
- Your health insurance is the primary insurer and Girl Scouts is secondary. The maximum health insurance coverage for Girl Scouts is \$15,000.00 for accidents and \$10,000.00 for illness.
- The health information given here is true and complete to the best of my knowledge and I understand it is my responsibility to notify Two Sentinels Camp Personnel of any new health conditions as they may arise.
- I understand that a Health Form must be filled out every year, but that an exam and doctor's signature is required only every 2 years. The medical exam must be within 24 months of camp. The Health Form must be on file with Two Sentinels Girl Scout Camp. However, any changes in medical conditions are my responsibility to report and have evaluated as necessary. Two Sentinels Girl Scout Camp may require a doctor's signature every year if health issues cause concerns for the camp health personnel and they think that the staff person's or camper's health may be at risk.

I hereby give permission to the physician, selected by the camp, to render emergency medical/surgical treatment on my behalf.

Signature: _____

Date: _____

You can help us insure that our programs are meeting the needs of girls coming to our camps by providing the following voluntary information. Please check the ethnic group that best applies to you:

____ Caucasian ____ Black ____ Hispanic ____ Native American ____ Japanese ____ Chinese
____ Filipino ____ Other Asian ____ Other _____ ____ Decline to state

Please return to: Two Sentinels Girl Scout Camp, PO Box 10906, Pleasanton, CA 94588

HEALTH HISTORY (Write YES or NO; **DO NOT** write "current" for immunizations)

ALLERGIES:

OTHER:

IMMUNIZATIONS DATES: (Year series completed or year of last booster)

___ Hay Fever	___ Asthma	___ Lyme Disease	___ / ___ / ___ Adult Tetanus
___ Poison Oak	___ Heart Disease	___ Sickle Cell	___ / ___ / ___ Diphtheria
___ Insect Stings	___ Arthritis	___ Hypertension	___ / ___ / ___ Oral Polio
___ Penicillin	___ Ear Infection	___ Chicken Pox	___ / ___ / ___ Measles
___ Other Drugs	___ Menstrual Problems	___ Contact Lenses	___ / ___ / ___ Mumps
___ Foods (list below)	___ Diabetes	___ Glasses	___ / ___ / ___ Rubella (German Measles)
___ Animals (list below)	___ Dizziness	___ Dental Braces/retainer	___ / ___ / ___ Hepatitis B
___ Other (list below)	___ Seizures	___ Hearing Aid	___ / ___ / ___ Hib
	___ Fainting	___ Other _____	___ / ___ / ___ Other _____

Details of any YES answers above: _____

Known recent exposure to contagious disease? _____ What and when? _____

Recent hospitalizations, operations, serious injuries, or illnesses lasting more than 5 days:
_____ Date _____ Date _____
_____ Date _____ Date _____

Any chronic disease? _____ If yes, describe: _____

Are you currently taking any medication? _____ If yes, state what it is and for what: _____

Are you currently under care of a physician or psychologist? _____ If yes, details: _____

Any special diet requirements? _____ If yes, describe: _____

Any activity restrictions at camp? _____

PHYSICIAN'S STATEMENT

Date of Exam: _____

I have examined _____ within the past 24 months. In addition, the health history and immunizations have been reviewed. There are no apparent contra-indications to participating in routine camp activities. There are no recent operations, illnesses, or injuries. Please note that the camp is located at an elevation of 8,000 feet.

Special problems: _____

Allergies: _____

Medications: _____

Physician's signature: _____ Date _____

Name (print): _____ Phone: (_____) _____

Address: _____