



Mail form to:

TS Girl Scout Camp PO Box 10906
Pleasanton, CA 94588

STAFF MEMBER: Complete form through Part VII - Signature section on the back.

PHYSICIAN: Complete statement on back of form.

YOUR 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'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 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:		

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, 2018**

\*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  DOES  DOES NOT preclude 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