Girl Scouts

Staff Health History Record with Physical

DUE MAY 15, 2019

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, 2019**

*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