Girl Scouts
Girl Scouts of Central Illinois

GIRL/ADULT HEALTH RECORD

This form is required for Resident Camp, Day Camp and trips of 3 days or more.

**Fill out all sections completely. Indicate None or Does Not Apply as necessary.

This form is required annually for each girl participating in a Girl Scout day camp and/or resident camp program.

ADMINISTRATIVE USE ONLY:

Program Name _____

Session Number _____ Dates

A. Participant Name (Last, First, Initial)	Name and relationship of parent/guardian completing this form			Phone ( )		
Address (Street & Number)	City or Town	State	Zip Code	Date of Birth	Age	Sex

B. EMERGENCY/TRANSPORTATION CONTACT – Must include parent/guardian or person completing form.

Relationship Key: M=Mother, SM=Stepmother, F=Father, SF=Stepfather, GP=Grandparent, O=Other

NAME	RELATIONSHIP	DAY PHONE	EVENING PHONE	CELL PHONE	THIS PERSON IS AN EMERGENCY CONTACT.	MY DAUGHTER MAY BE RELEASED TO THIS PERSON.
		( )	( )	( )	o Yes o No	o Yes o No
		( )	( )	( )	o Yes o No	o Yes o No
		( )	( )	( )	o Yes o No	o Yes o No
		( )	( )	( )	o Yes o No	o Yes o No

Physician's name _____ Phone (_____)_____ Dentist's name _____ Phone (_____)_____

Are there any legal custodial issues we should be aware of? o Yes o No If yes, please explain. _____

C. HEALTH HISTORY – To be completed by parent/guardian. Check all that apply.

ALLERGIES (Complete reverse side.)	DISEASES	CHRONIC OR RECURRING ILLNESS	OTHER HEALTH CONDITIONS	
❒ Animals	❒ Chicken pox	❒ Asthma	❒ ADD/ADHD	❒ Hearing impairment
❒ Food	❒ Eating disorder	❒ Bleeding disorders	❒ Bedwetting	❒ Learning disabilities
❒ Hay fever/Pollen	❒ German measles	❒ Diabetes	❒ Behavioral disturbances	❒ Menstrual cramps
❒ Insect stings	❒ Measles	❒ Ear Infections	❒ Constipation	❒ Motion sickness
❒ Medicine/Drugs	❒ Mononucleosis	❒ Heart defect/disease	❒ Depression	❒ Night terrors
❒ Plants	❒ Mumps	❒ Hypertension	❒ Diarrhea	❒ Nosebleeds
❒ Other (Specify)	❒ Sickle cell anemia	❒ Kidney disease	❒ Emotional disturbances	❒ Pediculosis (lice)
_____	❒ Other (Specify)	❒ Musculoskeletal disorders	❒ Fainting	❒ Sleepwalking
	_____	❒ Seizures/Epilepsy	❒ Frequent colds	❒ Wears glasses/contacts
		❒ Sinusitis	❒ Frequent headaches	❒ Wears orthodontic devices
		❒ Tuberculosis	❒ Frequent sore throats	❒ Other (Specify)
		❒ Other (Specify)	❒ Frequent stomach aches	_____
		_____		

In the last year, has your daughter had:
- ❒ an injury/illness requiring medical attention
- ❒ a surgical operation or fracture
- ❒ restrictions from participation in physical education
- ❒ an illness lasting longer than 5 days
- ❒ hospital treatment
- ❒ exposure to contagious disease

Is your daughter currently:
- ❒ receiving psychological counseling
- ❒ under a physician's care
- ❒ restricted in physical activity
- ❒ taking prescription medication (Complete reverse side.)
- ❒ taking over the counter medication (Complete reverse side.)
- ❒ taking no medication on a routine basis

Please explain any items checked, give dates, and include any information that would be helpful to camp staff in relation to these health conditions. Add a separate sheet if needed. Allergies and medications should be explained on reverse side.

_____
_____
_____

D. OTHER INFORMATION

Has your daughter been taught about menstruation? o Yes o No

Has your daughter begun menstruation? o Yes o No

Specify any special dietary regimen to be followed _____
_____

Specify activities to be encouraged _____
_____

Specify activities to be restricted _____
_____

List necessary adaptations or limitations _____
_____

E. PERMISSION TO TREAT

My daughter has permission to take or use the following:
- ❒ Advil/Ibuprofen
- ❒ Midol
- ❒ Tylenol/acetaminophen
- ❒ Calamine/Cala-gel/Aloe gel
- ❒ Hydrocortisone cream
- ❒ Neosporin
- ❒ Benadryl/antihistamine (oral)
- ❒ Robitussin/expectorant
- ❒ Sudafed/decongestant
- ❒ Cough Drops
- ❒ Chloraseptic/Throat spray
- ❒ Tums/Maalox/Mylanta/antacid
- ❒ Kaopectate/anti-diarrheal
- ❒ Milk of Magnesia/laxative
- ❒ Swimmer's Ear/alcohol
- ❒ Other _____

This health record, including the allergy and medication information on the reverse side, is complete and accurate. My daughter has my permission to engage in all prescribed activities, including strenuous activities such as hiking, swimming, climbing hills, and horseback riding (if applicable), except as noted by me and the examining physician.

I give my permission for the camp staff to obtain in-camp or out-of-camp medical treatment for my daughter should the need arise while she is at camp. In case of emergency, if none of the above can be contacted, I consent to treatment for my daughter under the supervision of and as deemed advisable by a physician licensed under the Medicine Practice Act. If my daughter is out of camp on a trip, I will not be contacted before medical treatment is given.

HEALTH INFORMATION PRIVACY STATEMENT

The **Girl/ Adult Health Record for Camp** is for health care concerns at Girl Scout day camp or resident camp sessions only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health service supervisor at the camp. Minimal necessary information may be shared with other staff/volunteers in order to provide adequate participant safety and health care. Girl Scouts of Central Illinois, will retain the health form until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature of Parent/Guardian_____ Date_____

Continued on Back Side

PARTICIPANT NAME (LAST, FIRST, INITIAL) _____ DATE_____

F. ALLERGIES – To be completed by the parent/guardian. List all known allergies. Attach a separate sheet if necessary.

MEDICATION ALLERGIES	REACTION OR SYMPTOMS	MANAGEMENT OR TREATMENT

FOOD ALLERGIES	REACTION OR SYMPTOMS	MANAGEMENT OR TREATMENT

OTHER ALLERGIES (insect stings, hay fever, asthma, animal dander, etc.)	REACTION OR SYMPTOMS	MANAGEMENT OR TREATMENT

G. MEDICATION INFORMATION – To be completed by the parent/guardian. Your daughter's over-the-counter and prescription medications will need to be brought with her to camp in the original containers with their correct label and dosage information. Attach a separate sheet if necessary.

MEDICATION	CONDITION TREATED	DOSAGE	TIME OF DAY	TAKEN WITH FOOD
			o 7:45 a.m. o 12:15 p.m. o 6:00 p.m. o Bedtime o As needed o Other _____	o Yes o No
			o 7:45 a.m. o 12:15 p.m. o 6:00 p.m. o Bedtime o As needed o Other _____	o Yes o No

DOCTOR'S APPROVAL TO SELF-ADMINISTER INHALERS

Please allow _____ to self-administer her inhaler. _____ has asthma and understands how to use the inhaler, since she has been self-administering the inhaler for some time. (In the past, nurses kept the inhalers in their office, but the law has changed since Governor Ryan signed SB979 into law amending the School Code to require a school to permit the student to self administer.) _____ _____

Doctor's Signature and Date Parent Signature and Date

PHYSICIAN DOCUMENTATION

- Day Camp Participants: Complete section J (immunizations chart) only. Tetanus booster must be current (within 10 years.) No exam is necessary.
- Resident Camp Participants: Complete all sections (H-L) below. Required health exam must be completed by licensed physician, nurse practitioner, physician's assistant, or registered nurse within 24 months prior to camp session. Tetanus booster must be current (within 10 years.)

H. HEALTH EXAMINATION

Patient's first and last name _____ Height _____ Weight _____ Blood Pressure _____

EYES – Without Glasses: R 20/_____ L 20/_____ With Glasses: R 20/_____ L 20/_____ EARS – Hearing R _____ Hearing L _____

I. ORGANS, ETC.	SATISFACTORY	NOT SATISFACTORY	NOT EXAMINED
Abdomen			
Color vision			
General physical and emotional status			
Genitalia			
Heart			
Hernia			
HGB *			
Lungs			
Musculoskeletal			
Nose			
Skin			
Teeth			
Throat			
Urinalysis *			

* Not required for every health examination. A Girl Scout in grades K-6 should have this test if she has not already had it, either when entering school or at any time since. A Girl Scout in grades 7-12 should have this test if she has not had it since entering puberty.

J. IMMUNIZATIONS	YEAR PRIMARY SERIES COMPLETED	YEAR OF LAST BOOSTER
Diphtheria		
DTP/DTaP		
Hepatitis B		
HIB (Haemophilus influenza b)		
Measles		
Oral polio		
Pertussis (Whooping Cough)		
Rubela		
TD (Adult tetanus-diphtheria toxoid)		
Tetanus		_____ (w/in last 10 yrs)
Tuberculin test	Year last given _____ Result _____	
Other		

K. PHYSICIAN'S COMMENTS AND RECOMMENDATIONS

Note any restrictions, limitations, needed adaptations, and/or guidelines for care and treatment of health conditions. Give details or indicate management of significant illness.

_____

_____

_____

L. LICENSED PHYSICIAN'S RELEASE

This person is in satisfactory condition and may engage in all prescribed activities, including strenuous activities such as hiking, swimming, climbing hills, and horseback riding (if applicable), except as noted.

Physician's signature _____ Date of physician's signature _____ Date of patient's last health examination _____

Physician's name (please print) _____ Facility/Office name _____ Phone (_____)_____

Facility address _____ City _____ State _____ Zip _____