

Health History Form: Required for all campers attending Camp Evelyn

Please type or write clearly and legibly.

Name (Last, First, Middle Initial):	Date of Birth:	Age:	
Home Address:	City:	St:	Zip:
Parent/Guardian:	Phone:	Alt. Phone:	

Emergency Contact Information:

In case of an emergency, notify (parent/guardian will be contacted first, please provide additional person)

Emergency Contact:	Relationship:	Phone:
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Health Insurance Information

Bills for medical visits will be mailed to home address above unless box checked, complete insurance information is supplied, and insurance card is provided:

<input type="checkbox"/> Bill me at home address	<input type="checkbox"/> Insurance card and all information attached
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Allergies: Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Does your camper suffer from Anaphylaxis? Yes No
 Does your camper carry an Epipen? Yes No
 Does your camper carry an inhaler? Yes No

*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	

Medications: List any medications currently taken, including dosage schedule and specific instructions for use.

Medication	Purpose	Dosage	Time(s) to be given Please Circle
1.			AM NOON DINNER BEDTIME AS NEEDED
2.			AM NOON DINNER BEDTIME AS NEEDED
3.			AM NOON DINNER BEDTIME AS NEEDED

Over-the-Counter Medications: The following will be on hand in case your camper experiences minor health discomfort during her stay.

- Tylenol/Acetaminophen
- Sudafed/Decongestant
- Cough Drops or Throat Lozenges
- Aspirin (fever reducer)
- Pepto Bismol
- Skin Ointments or Sprays (Anti-Itch, Neosporin, Calamine Lotion)
- Ibuprofen (pain/swelling)
- Tums/Antacid
- Benadryl/Antihistamine
- Laxatives (constipation)
- Robitussin/Expectorant
- Imodium (anti-diarrhea)

Please list those medications you will not permit the camp staff to administer to your camper and/or special considerations regarding over-the-counter medications.

Does your camper have a Special Medical or Dietary Regiment to be followed? Yes No

If so, please explain: _____

*Complete the authorization found on page 16 and submit with your camper's registration in addition to the Health History Form.

Medical Examination Form: Required for campers attending Camp Evelyn for three or more nights

Name: _____ **Date of Exam:** _____

This section is to be completed by a physician, physician assistant, or a registered nurse after the review of the completed health history. A parent/guardian must complete all the information in the Health History to the best of their knowledge and sign before meeting with licensed professional.

Medical Examination:

Height: _____	Weight: _____	Pulse Rate: _____	Temperature: _____	B. P.: _____ / _____
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined				
_____ Eyes	_____ Extremities	___ General Physical State		___ General Emotional State
_____ Lungs	_____ Hernia	Has this person menstruated?		Yes or No
_____ Heart	_____ Ears	If so, is her menstrual history normal? _____		
_____ Nose	_____ Skin	_____		
_____ Abdomen	_____ Appearance/Nutrition	_____		

Does this applicant have any conditions which might restrict activity at camp; such as chronic disease, weight or limit participation in swimming or other strenuous activity? Yes No

If yes, please explain: _____

Record of Immunization: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

	Date Series was Completed & Year of Last Booster
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)	_____
Tetanus booster (dT) or (TdaP)	_____
Mumps, measles, rubella (MMR)	_____
Polio (IPV)	_____
Haemophilus influenzae type B (HIB)	_____
Pneumococcal (PCV)	_____
Hepatitis A	_____
Hepatitis B	_____
Meningococcal meningitis (MCV4)	_____

Examiner's Information

Licensed Professional Name:	Phone Number:		
Address:	City:	St:	Zip:

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is in satisfactory condition and may engage in all usual camp activities, including physically demanding activities except as noted.

Signature of Licensed Professional: _____ **State License Number:** _____ **Date:** _____

***Authorization for Health History and Medical Examination: Parent/Guardian Please Complete For All Campers**

I, the undersigned, am either a custodial parent or guardian of a minor (the "Minor"), and do hereby authorize the adult leaders and agents of the Girl Scouts of Manitou Council (collectively the "Authorized Persons") consent to dispense any medications as stated above and to any X-Ray, examination, anesthetic, medical, or surgical diagnosis or treatment, and hospital care for the Minor under the general or special supervision and upon the advice of or to be rendered by a licensed physician, and to consent to any X-ray, examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care for the Minor by a licensed dentist. Each of the authorized persons may exercise the authority granted hereby individually and without the knowledge, consent, or joint action of any other of the authorized persons. It is understood that an effort shall be made to contact the parent or guardian prior to rendering treatment to the Minor, but that any of the above treatments will not be withheld if the parent or guardian cannot be reached in the event of an emergency.

I give permission for _____ to participate in all camp activities, with the exception of those restrictions indicated above and to ride in a vehicle driven by a licensed adult driver in a vehicle which has at least minimum liability insurance as required by the State of Wisconsin, for Girl Scout camp activities.

This Health History and Medical Examination (if applicable) Form is complete and accurate.

Signature of Parent/Guardian: _____ **Date:** _____

Return Completed form to Girl Scouts of Manitou Council: 5212 Windward Court, Sheboygan, WI 53083 P: (920) 565-4575 F: (920) 565-4583