girl scouts of black diamond

GIRL Fest Health History

(This section to be completed by parent/guardian)

NAME: ______________________________________ **DOB:** ______________

Please type or write clearly and legibly.

Name: (Last, First, Middle Initial)	**Date of Birth:** (XX/XX/XXXX)		**Sex:** **M** ☐ **F** ☐
Address:	**City:**	**St:**	**Zip:**
Cell Phone:			
Parent/Guardian (minors only)**:**	**Phone:**	**Alternate Phone:**	

Emergency Contact Information:

Name:	**Relationship:**
Phone:	**Alternate Phone:**

Health Insurance Information Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" below. *(Family insurance is primary insurance in case of accident or illness; Girl Scout insurance is secondary.)*

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

HEALTH INFORMATION STATEMENT

The **Health History** is for health care concerns at the specified event 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 care supervisor for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years in the case of treatment. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. **I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.** Yes ☐ No ☐

Do you have a Special Medical or Dietary Regimen to be followed? Yes ☐ please explain No ☐

____

Have you ever had any adverse reactions to general anesthetics? Yes ☐ please explain No ☐

____

RECORD OF IMMUNIZATIONS

I/my child is up to date on all immunizations required. Yes ☐ No ☐ Date of last Tetanus Shot (required): ___________

Medical Conditions (including any precautions or restrictions on activities) **Check all that apply and explain in detail checked answers:**

☐	Diabetes	☐	Asthma	☐	Wears glasses or contacts
☐	Heart Defects/Disease	☐	Headaches/Migraines	☐	Hearing Impairment
☐	Hypertension	☐	Ear Infections	☐	Speech Impairment
☐	Musculoskeletal Disorders	☐	Sinusitis (Sinus Infections)	☐	Eating Disorders (Anorexia, Bulimia, etc.)
☐	Convulsions/Epilepsy/Seizures	☐	Nosebleeds	☐	Mental/psychological disorder
☐	Kidney/bladder illness	☐	Fainting	☐	Had surgery or hospitalized in the last 5 yrs
☐	Intestinal Disorders/Constipation	☐	Bedwetting	☐	Currently under doctor's care
☐	Hernia	☐	Menstrual cramps	☐	Physical Restrictions
☐	Arthritis	☐	Sleep disturbance	☐	Other: ____________________
☐	Bleeding disorder	☐	CPAP - Yes ☐ NO ☐		

Name of Condition	Effects

Name of Condition	Effects

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

Medication	Dosage Schedule	Purpose/Specific Instructions
	Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other ☐	
	Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other ☐	
	Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other ☐	

Over-the-Counter Medications: The following non-prescription medications may be stocked in the camp first aid station and are used on an as needed basis to manage illness and injury**. Check any that your camper *should not* be given.**

☐	Acetaminophen (Tylenol™)	☐	Calamine Lotion	☐	Bee sting relief
☐	Diphenhydramine (Benedryl™)	☐	Antibiotic ointment (Neosporin™)	☐	Bactine Spray
☐	Ibuprofen (Advil™, Motrin™)	☐	Hydrocortisone Cream (anti-itch)	☐	Bug repellant (all kinds)
☐	Naproxin (Aleve™)	☐	Aloe Vera gel (for sunburn	☐	Eye drops/wash
☐	Excedrin™ (acetaminophen/aspirin/caffeine)	☐	Hand sanitizer	☐	Hand lotion
☐	Pepto Bismol	☐	Sunscreen	☐	Tampons (all brands)
☐	Tums/Rolaid	☐	Alcohol pad or swabs	☐	Feminine pads (all brands)

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

Do you suffer from Anaphylaxis? Yes ☐ No ☐ *Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Do you carry an EpiPen? Yes ☐ No ☐ Do you carry an inhaler? Yes ☐ No ☐

TRANSPORTATION RELEASE: I authorize transportation for myself/my child by emergency vehicle to an appropriate health care facility and pre- hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of me/my child. It is my expressed intention to hold Girl Scouts of Black Diamond Council harmless for any and all injuries, death or damages arising from or in any way related to any such transportation.

CONSENT TO TREAT: I hereby give permission to the designated Girl Scout First Aider on duty selected by the camp coordinator to administer any routine and approved medications listed on this form and to administer first-aid treatment, order X-rays, routine tests and treatment for the health of myself/my child, in the event I cannot be reached in an emergency. I hereby give permission to the designated Girl Scout First Aider on duty selected by the camp coordinator to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above. The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to troop/group leaders, drivers, medical personnel, etc.

This health history is correct so far as I know, and the person herein described has permission to engage in all planned trip activities except as noted by the examining physician or me. I have read the camp description and agree to cooperate with all policies. I understand that some campers will have the opportunity to participate in activities such swimming, canoeing, challenge courses, zip lining and trips off the camp premises. This is not a guarantee that my child will participate in all of the activities. Although care is given to greatly reduce risk through safety procedures, education and equipment, I understand adventure programs are not without an element of danger. These risks include damage to property and temporary or long-term injury to the person. I understand the risks involved with this type of program, and I feel the benefits outweigh the potential hazards of the program.

______________________________ OR ______________________________

Signature of Adult Participant **Date** **Signature of Parent/Guardian of minor participant** **Date**

GIRL Fest Physical Examination

NAME: ______________________ **DOB:** __________ **Date of Exam:** ____________

Medical Examination This section is to be completed by a health professional after the review of health history. Adult must complete all the information in the Health History to the best of their knowledge and sign before meeting with licensed professional. The examination is completed by a licensed physician, nurse practitioner, physician's assistant, or registered nurse within the preceding **12 months** unless a health issue is present.

Examiner: Please fill in the following information

Yes	NO	Allergies or Reactions	Explain		Yes	NO	Allergies or Reactions	Explain
		Medication					Plants	
		Food					Insect bites/stings	

Height (in)__________ Weight (lbs)__________ Blood Pressure________/______ Pulse __________

	Normal	Abnormal		Normal	Abnormal
Eyes			Genitalia/hernia		
Ear/Nose/Throat			Musculoskeletal		
Lungs			Neurological		
Heart			Other		
Abdomen					

Explain Abnormalities

Record of Immunization A copy of the shot record may be substituted.

Yes	No	Had Disease	Immunization	Date
			DTap/Tdap (diphtheria/tetanus/pertussis)	
			DT/Td (diphtheria/tetanus)	
			Tetanus booster	
			MMR (Measles, Mumps, Rubella)	
			Varicella (Chicken Pox)	
			MMRV (after 2005) (MMR + Varicella)	

Prior to 1971 measles, mumps and rubella were given as individual vaccines

Yes	No	Had Disease	Immunization	Date
			Measles	
			Mumps	
			Rubella	

Yes	No	Had Disease	Immunization	Date
			Hib	
			Meningitis	
			Influenza	
			Pneumonia	
			IPV/OPV (Polio)	
			Hepatitis A	
			Hepatitis B	
			Other	

Medical restrictions to participate Yes ☐ No ☐

If Yes:

1. Please explain any chronic or recurring illness, or health concerns as listed on the medical history.
2. Recommendations and/or restrictions while at camp.

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Medical Professional Signature Date

Printed name ______________________

Address:______________________

City______________St_____ZIP _______

Office Phone______________________