Girl Health History Record with Physical

Please mail to: Camp Butano Creek
1771 Dawn Street
Livermore, CA 94550 ***DUE DATE: MAY 18!***

PARENT: Complete form through Part VII - Parent Consent section on the back.
PHYSICIAN: Complete statement on back of form.

PART I: GIRL RECORD

Child's Name - Last, First, Middle Initial | Birth Date - MM/DD/YYYY | Age

Home Address | City/State/Zip | Family E-Mail Address (For GSNC use only)

Parent/Guardian Name | Day Time Telephone ( ) | Evening Phone ( ) | Cell Phone ( )

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PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name | Day Time Telephone ( ) | Evening Phone ( )

Home Address | City/State/Zip | Relationship to Girl

PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: ______________________________ Telephone: ( ) ______________________

Address of family PHYSICIAN:

Home Address | 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 does your child 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: ______________________________

____

List any previous medical treatments, operations or serious injuries, provide dates: ______________________

PART V: MEDICATION

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the child's name, address, dosage and frequency. Please label with child's name and dosage for any OTC drugs: anti-histamines, vitamins, fluoride, etc. All medications are turned into the Health Center.

Over- the-counter (OTC) medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any OTC medicines you DO NOT want your child to receive:

____
____
____

Is your child taking any medications? ___ NO ___ YES
If **YES**, list medication, dosage, and possible side effects.

MEDICATION DOSAGE POSSIBLE SIDE EFFECTS

____
____
____
____

PART VI: IMMUNIZATION HISTORY - REQUIRED

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 from parents/guardians: ____

____

PART VII: PARENT CONSENT

This health history is correct as far as I know, and my child has permission to engage in all prescribed activities, except as noted by me and the physician. My child is in good health. I give permission for my child to receive 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 cannot be reached in an emergency, I give my permission for my child ____, to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action. **All medications being taken are listed on this form.*

Parent/Guardian Signature: ____**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 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