

Camper Health History Record with Physical

Please return form to: Camp Butano Creek, 1771 Dawn St., Livermore, CA 94550, **by MAY 18th**

Please download and save this form before entering the information. You may also choose to print and complete the form manually, *please print clearly.*

Camper Name: _____ Birthdate (month/ date/ year): _____ Gender: _____

Address (street address, city/state, zip): _____

Parent / Legal Guardian: _____ Phone: _____

Parent / Legal Guardian: _____ Phone: _____

Medical and Insurance Information:

Name of Family DENTIST: _____ Phone: _____

Name of Family PHYSICIAN/Clinic: _____ Phone: _____

Name of Carrier: _____ Policy#: _____

Insured's Name: _____ Member ID#: _____

Insured's Employer (if insurance is through work): _____

Others who could be contacted to authorize medical treatment:

Name: _____ Relationship to camper _____ Phone: _____

Name: _____ Relationship to camper _____ Phone: _____


PART A: Allergies	Check those that apply. Specify cause and nature of reaction (<i>i.e., Penicillin causes hives</i>)		
	<input type="checkbox"/> Animals:	<input type="checkbox"/> Insect Stings:	<input type="checkbox"/> Plants/Trees:
	<input type="checkbox"/> Hay fever:	<input type="checkbox"/> Pollen:	<input type="checkbox"/> Poison Oak:
	<input type="checkbox"/> Food:		
	<input type="checkbox"/> Medicine / Drugs:		
	<input type="checkbox"/> OTHER:		
	In case of an allergic reaction, respond by:		
PART B: Medical History	Check those that apply		
	<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Mumps
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emotional Disturbances	<input type="checkbox"/> Muscle Disease / Disorder
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nervous System Disorder
	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Eyes: Contact Lenses	<input type="checkbox"/> Nosebleeds
	<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Eyes: Glasses	<input type="checkbox"/> Orthodontic/Dental Appliances
	<input type="checkbox"/> Behavioral Changes	<input type="checkbox"/> Fainting	<input type="checkbox"/> Physical Disabilities
	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> German Measles	<input type="checkbox"/> Runny Nose
	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Seizures
	<input type="checkbox"/> Bleeding / Clotting Disorder	<input type="checkbox"/> Headaches, frequent	<input type="checkbox"/> Sickle Cell Trait or Disease
	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Sinusitis
	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Defect / Disease	<input type="checkbox"/> Skeletal Disease / Disorder
	<input type="checkbox"/> Concussion	<input type="checkbox"/> Hepatitis A / B / C	<input type="checkbox"/> Skin Conditions
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sleep Disturbance
	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sleep Walking
	<input type="checkbox"/> Cough	<input type="checkbox"/> Measles	<input type="checkbox"/> Sore Throat
	<input type="checkbox"/> Depression	<input type="checkbox"/> Menstrual Complications	<input type="checkbox"/> Special Dietary Regimen
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stomach Upsets
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Urinary Tract Infection
	<input type="checkbox"/> Down's Syndrome	<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Visual Impairments
	<input type="checkbox"/> Ear Infection		
	<input type="checkbox"/> OTHER:		

PLEASE EXPLAIN:

- Indicate any information useful to the adult in charge in relation to any of the health conditions chosen in **PART B**.
- Indicate any activity to be encouraged or restricted.

Dietary Needs / Restrictions:

PART C:		REQUIRED: Please complete		
Immunization & Disease History	Immunization	Year Primary Series Completed	Year of Last Booster	Has had Disease YES or NO
	D.T.P.			
	Chicken Pox			
	Diphtheria			
	Hepatitis B			
	Hib <i>Haemophilus influenza B</i>			
	Measles			
	Mumps			
	Oral Polio			
	Pertussis <i>(whooping cough)</i>			
	Rubella <i>(German Measles)</i>			
	Td <i>(tetanus/diphtheria)</i>			
	Tetanus			
	Tuberculin Test Result (most recent)			
OTHER:				

MEDICATIONS		Listed are all prescribed medication(s) that my child will routinely take. Attach a separate list if necessary.		
	Medication	Dosage	How often?	
Please initial below, if applicable				
	Enter name of camper: [REDACTED] will self-administer the following medication(s).			
*	<input type="checkbox"/> Bronchial Inhaler			
*	<input type="checkbox"/> Diabetic Medication			
*	<input type="checkbox"/> Epi-pen			
*	<input type="checkbox"/> OTHER:			

Over-the-Counter Medication(s):

Over-the-counter medications will be used to treat routine illness per treatment protocols. Acetaminophen is used in place of aspirin.

Camper can have: Pain medications Cough syrup Antibiotic ointment Fever reducer Digestive relief

OTHER: _____

Camper CANNOT have: _____

Health Information Privacy Statement:

The Camper Health Form is for health care concerns during camp. 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 of the camp. Minimal necessary information may be shared with camp staff/volunteer(s) in order to provide adequate participant safety and health care. The health history record will be retained by Girl Scouts of Northern California until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the camper. Access to the information will be limited, but copies may be requested from the camp, by the camper or their legal representative.

Transportation Release:

I authorize transportation for 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 my child. It is my expressed intention to hold Girl Scouts of Northern California harmless for any and all injuries, death or damages arising from or any way related to any such transportation.

Consent to Treat:

I hereby give permission to the physician selected [by the camp nurse / first aider] to order x-rays, routine tests, and treatment for the for the health of my child, in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the camp nurse/first aider to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child named above.

The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to Camp Staff, drivers, medical personnel, etc.

Parent's / Legal Guardian Authorization:

This health history is correct so far as I know, and the person herein described has permission to engage in all planned camp activities except as noted by the examining physician or me. I have read the above procedures for handling the health history form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature of Parent/Legal Guardian	Relationship to Camper	Date
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Print Name of Parent/Legal Guardian	Phone	Email Address
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Record of Health Examination:

All participants attending resident camp or working at resident camp are required to have a completed health examination by a: **LICENSED PHYSICIAN-MD; PHYSICIAN ASSISTANT – PA; or NURSE PRACTITIONER – NP** acting under the supervision of a licensed MD may also complete and sign the health examination.

The health exam must be completed within 12 months of the registered camp session. **DUE DATE for ALL health records for participants is MAY 18TH.** If your physical can not be completed by this date, you will be able to continue to submit/upload this form, up to 1 week prior to the start of the camp session (with Camp Director or Camp Nurse approval).

Participant Name: _____

To be completed by MD, PA or NP:

I have examined the above applicant within the past 12 months. **Date of exam:** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____

In my opinion, the above participant's condition is acceptable to participate in an active outdoor camp program. Yes No

If No, please list any activities that should be limited:

The participant is under the care of a physician for the following condition: *(Please include current treatment, including any medications):*

Name of MD, PA, or NP: _____

Signature of MD, PA, or NP: _____

Phone: _____

Date Signed: _____

Medical Office Stamp or Address