girl scouts of northern california

Staff 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*.

Staff *"Camp"* Name: _____

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

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

Cell phone: _____ Daytime phone: _____ Evening Phone: _____

Parent/Legal Guardian (if staff under 18): _____ Phone: _____

Medical and Insurance Information:

Name of Family DENTIST: _____ Phone: _____

Name of Family PHYSICIAN/Clinic: _____ Phone: _____

Name of Insurance Carrier: _____Policy#: _____

Insured's Name: _____ Member ID#: _____

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

Others who could be contacted to authorize medical treatment:

Name: _____ Relationship to staff_____ Phone: _____

Name: _____ Relationship to staff_____ Phone: _____

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

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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 *Haemophilus influenza B*			
	Measles			
	Mumps			
	Oral Polio			
	Pertussis *(whooping cough)*			
	Rubella *(German Measles)*			
	Td *(tetanus/diphtheria)*			
	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 staff: _____ will self-administer the following medication(s).		
*	☐ Bronchial Inhaler		
*	☐ Diabetic Medication		
*	☐ Epi-pen		
*	☐ 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 Staff 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 myself or my child (if staff under 18) 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 myself or my child (if staff under 18). 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 myself or my child (if staff under 18), 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 myself (if I am unable to do so) or my child (if staff under 18) 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.

Participant Authorization (if staff over 18):

To the best of my knowledge this health history is correct. I am able to engage in all planned camp activities except as noted by the examining physician. 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 Participant **Date**

Print Name of Participant **Phone** **Email Address**

Parent's / Legal Guardian Authorization (if staff under 18):

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**

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 PRACTIONER – 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, of camp attendance. **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)*:

_____

_____

_____

Please note that Tuberculin test is only required for kitchen staff. *Required within 24 months for all kitchen staff: Cook, Assistant Cook, Dining Hall Director.*

TUBERCULIN TEST:

Skin Test _____ X-ray_____ Result_____

Medical Office Stamp or Address

Name of MD, PA, or NP: _____

Signature of MD, PA, or NP: _____

Phone: _____

Date Signed: _____