girl scouts of michigan shore to shore

Health History & Consent Form

Location of Program ❑ Camp Anna Behrens ❑ Camp Sakakawea
Program Date: _____ Program Name:_____

Health History: Required for participants attending resident camp, troop Camping at resident camp, and extended troop trips lasting three nights or longer.

Physical Examination: Separate document. Required for participants attending a camp/trip that is three nights or longer. Form needs to be completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse. Completed within 24 months of program the participant is attending. **PLEASE KEEP A COPY FOR YOUR RECORDS.**

Medication Log: Separate document. To be completed if participant is Bringing prescription medications to program.

If attending a resident camp program, mail this completed form by May 25 to:

Girl Scouts of Michigan Shore to Shore
Attention: Camp Forms
3275 Walker Ave NW
Grand Rapids, MI 49544

If registering for resident camp program after May 25 mail completed form to above address at least two weeks prior to your camper's session.

PARTICIPANT INFORMATION

Participant Name_____ Home Phone _____ Age_____ Birth Date ____/____/_____

Mailing Address_____ City_____ State_____ Zip Code_____

If a minor: Parent/Guardian #1's Name_____ Parent/Guardian #1's Name_____

Parent/Guardian #1's Phone_____ Parent/Guardian #1's Phone_____

EMERGENCY CONTACT INFORMATIONS (if participant is a minor, please list a non-parent/guardian contact)

Person to be notified_____ Relationship to camper_____

Phone #1_____ Phone # 2_____

INSURANCE INFORMATION

Insurance Company_____ Members Services Phone _____

Address_____ Name of insured_____ ID Number_____

HEALTH INFORMATION

Check "Yes" or "No" for each statement. Explain "Yes" answers below and explain any accommodations needed.

1. Asthma? ❑Yes ❑ No
2. Diabetes? ❑Yes ❑ No
3. Seizures/epilepsy? ❑Yes ❑ No
4. Frequent ear infections? ❑Yes ❑ No
5. Frequent sore throats? ❑Yes ❑ No
6. Sinusitis? ❑Yes ❑ No
7. Bronchitis? ❑Yes ❑ No
8. Fainting/dizziness? ❑Yes ❑ No
9. Stomach upset? ❑Yes ❑ No
10. Constipation/diarrhea? ❑Yes ❑ No
11. Bed wetting? ❑Yes ❑ No
12. Urinary tract infections? ❑Yes ❑ No
13. Sleeping disorder/sleep walking? ❑Yes ❑ No
14, Heart defect/disease? ❑Yes ❑ No
15. Bleeding/clotting disorders? ❑Yes ❑ No
16. Hypertension? ❑Yes ❑ No
17. Recent infectious disease? ❑Yes ❑ No
18. Chronic/reoccurring illness? ❑Yes ❑ No
19. Skin conditions? ❑Yes ❑ No
20. ADD/ADHD? ❑Yes ❑ No
21. Autism Spectrum Disorder? ❑Yes ❑ No
22. Emotional disability? ❑Yes ❑ No
23. Learning disability? ❑Yes ❑ No
24. Physical disability? ❑Yes ❑ No
25. Visual disability? ❑Yes ❑ No
26. Deaf/hard of hearing? ❑Yes ❑ No
27. Behavioral problems? ❑Yes ❑ No
28. Eating Disorders? ❑Yes ❑ No
29. Has this person menstruated? ❑Yes ❑ No
    a. If not, has she been told about it? ❑Yes ❑ No
    b. If so, is her menstrual history normal? ❑Yes ❑ No
30. Operations/serious injury? ❑Yes ❑ No
31. Other diseases/conditions? ❑Yes ❑ No

Explanation of "Yes" answers_____

_____

DIETARY RESTRICTIONS
Please specify any accommodations needed
❑Vegetarian ❑ Vegan ❑Glutton-free ❑ Lactose-free ❑ Other
_____

ALLERGIES
Please explain severity of allergies (contact, ingestion, smell, etc.
❑Drug ❑ Plant /Pollen/Insects ❑Food ❑ Other
_____

OVER THE COUNTER MEDICATIONS
- ❑ Tylenol/Acetaminophen
- ❑ Advil/Ibuprofen
- ❑ S Sudafed/decongestant
- ❑ Benadryl/antihistamine
- ❑ Tums/antacid
- ❑ Rubitussin/expectorant
- ❑ Calamine lotion
- ❑ Cough drops

HEALTH FORMS ARE CONSIDERED APART OF THE PERNAMENT CAMP RECORD AND WILL NOT BE RETURNED.

HEALTH INFORMATION PRIVACY STATEMENT

The **Health History Form** 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 b benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff, volunteers in order to provide adequate participant safety and health care. The health form will be retained by Girl Scouts of Michigan or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. 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 form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I authorize emergency medical treatment be given if needed for illness or injury.

This health history is complete and accurate. I give permission to engage in all prescribed activities, except as noted.

Signature of self or Parent/Guardian (if minor)_____

Date_____