



# Camp Menzies Camper Health History Form

Girl Scouts Heart of Central California | 6601 Elvas Avenue Sacramento, CA 95819 | [www.girlscoutshcc.org](http://www.girlscoutshcc.org)

Camper Name: \_\_\_\_\_ Bus Stop Location: \_\_\_\_\_  
Program: \_\_\_\_\_ Session#: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
number street  
city state zip Birthdate \_\_\_\_\_

Parents/Guardians:

(1) Name \_\_\_\_\_ Phone 1 \_\_\_\_\_  
Place of work \_\_\_\_\_ Title \_\_\_\_\_ Phone 2 \_\_\_\_\_

(2) Name \_\_\_\_\_ Phone 1 \_\_\_\_\_  
Place of work \_\_\_\_\_ Title \_\_\_\_\_ Phone 2 \_\_\_\_\_

If parents can't be reached, call (Name) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

## **INSURANCE COVERAGE:**

I understand that my personal insurance will be primary coverage for camper accidents and illnesses and Girl Scouts Heart of Central California's insurance is secondary up to a maximum of \$15,000 for accident, \$10,000 for illness and \$4,000 for dental claims. Exception: if the total claim is less than \$130, GSHCC will pay the full amount. On claims above \$130, GSHCC will coordinate payments for deductibles and co-pays. If you have questions, please contact GSHCC at 916-452-9181.

My insurance company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Company address: \_\_\_\_\_

Not currently insured – GSHCC reserves the right to subrogation if it is later determined that personal medical insurance was in place.

## **HEALTH HISTORY:**

**Does the camper have any food allergies or dietary restrictions we should be aware of? \_\_\_\_ Yes \_\_\_\_ No**

If yes, please explain (campers with severe food allergies should also complete form CM 34x)

**Does camper have any other medical conditions we should be aware of? \_\_\_\_ Yes \_\_\_\_ No**

If yes, please complete the Medical Information Form (CM 34) in consultation with your medical care provider and submit no later than four weeks prior to camp.

Recent operations or serious injuries \_\_\_\_\_ Date \_\_\_\_\_

Hospitalizations \_\_\_\_\_ Date \_\_\_\_\_

Any known recent illness or exposure to contagious disease (within the last six weeks)? \_\_\_\_ Yes \_\_\_\_ No Details \_\_\_\_\_

Is the child currently under the care of a physician or psychologist? \_\_\_\_ Yes \_\_\_\_ No Details \_\_\_\_\_

Please list any limitations or restrictions to activities while at camp? \_\_\_\_\_

Has child menstruated? \_\_\_\_\_ Has she received information on menstruation? \_\_\_\_\_ Menstrual problems? \_\_\_\_\_

Camper Name: \_\_\_\_\_ Bus Stop Location: \_\_\_\_\_  
 Program: \_\_\_\_\_ Session#: \_\_\_\_\_

**MEDICATIONS:** The following non-prescription medications are commonly stocked in camp health centers and are used on an as needed basis to manage illness and injury. ***Cross out those items the camper should not be given.***

Acetaminophen (Tylenol®)	Phenylephrine (Sudafed PE®)	Dextromethorphan
Chlorpheniramine maleate (cold meds)	Ibuprofen (Advil®, Motrin®)	Hydrocortisone 1% cream
Generic cough drops	Guaifenesin (Robitussin®)	Calcium Carbonate (Tums®)
Aloe	Chloraseptic (sore throat spray)	Lice shampoo or scabies cream (Nix® or Elimite®)
Topical antibiotic cream (Polysporin®)	Calamine lotion	Benzocaine (Oragel®)
Pseudoephedrine (Sudafed®)	Diphenhydramine (Benadryl®)	Clotrimazole (Lotrimin®)
Lidocaine (Sting Kill/Skeeter Stick®)		

**ATTACH A COPY OF THE CAMPER'S IMMUNIZATION HISTORY OR PROVIDE IMMUNIZATION DATES**

Immunization History	Year Primary Series Completed	Year of Last Booster	Immunization History	Year Primary Series Completed	Year of Last Booster
Diphtheria	_____	_____	Measles	_____	_____
Tetanus	_____	_____	Mumps	_____	_____
Whooping Cough	_____	_____	Rubella	_____	_____
Oral Polio	_____	_____	Other	_____	_____

List any medications being brought to camp with dosage and their purpose. Medication, both prescription and over-the-counter, **MUST** be in the original container; **camp CANNOT administer medication otherwise.** Prescription medication must be labeled with the camper's name and address and instructions. Add additional sheets as needed.

Medication Name	Dosage	Time of Administration	Purpose for Medication

**Activities and Risks**

Activities vary from program to program, and may include hiking, stewardship activities (for example, plant removal and trail maintenance), horseback riding, archery, canoeing, swimming, outdoor cooking (including the use of knives and propane stoves), fire building, backpacking, kayaking, surfing and sports. Some programs involve travel in camp vehicles driven by Girl Scouts Heart of Central California employees. I understand that by attending camp, my camper can be exposed to a variety of risks and hazards, foreseen and unforeseen, some of which are inherent and cannot be eliminated without fundamentally altering the unique characteristics of the camp program. These inherent risks include, but are not limited to, environmental risks and hazards, including rapidly moving, deep, or cold water; plants, insects, snakes, and predators, including large animals; falling and rolling rock; lightning; and unpredictable forces of nature, including weather that many change to extreme conditions without notice. Possible injuries and illnesses include allergic reactions, anaphylaxis, hypothermia, frostbite, sunburn, heatstroke, dehydration, infectious diseases, musculoskeletal injuries, and other mild or serious conditions or injuries including death. Emergency evacuation and medical care may be delayed thirty minutes or more due to the remote location of some camp activities. The above named camper has my permission to engage in all camp activities, except as noted by me.

**Medical**

The medical information I have provided above is correct and complete to the best of my knowledge. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby authorize Girl Scouts, through the appointed camp medical personnel, to provide routine medical health care; to administer medications; and to order X-rays, routine tests as deemed advisable by a licensed physician. It is understood that every effort will be made to contact me or the person noted above before taking this action. I understand that this permission is given in advanced of need to any diagnosis, treatment, or hospitalization. I give permission for this form to be photocopied for trips outside of camp.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_