SUMMER TROOP CAMPING
Permission Slip/Health Form

By June 1, 2012 Mail this completed form to
Girl Scouts of Nassau County
110 Ring Road West
Garden City, NY 11530

Dates of Camp Attendance_____

This information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Name_____Birth Date_____Age at camp_____
Last First Middle

Home address_____
Street Address City State Zip

Custodial parent/guardian:_____Phone_____

Home Address_____
(*if different from above) Street Address City State Zip*

Business Name_____Phone_____

Second parent or guardian:_____Phone_____

Address_____
(*if different from above) Street Address City State Zip*

Business Name_____Phone_____

Emergency contact_____Relationship_____

Home Phone_____Cell Phone_____Work Phone_____

IMPORTANT—THESE BOXES MUST BE COMPLETE FOR ATTENDANCE*

This health history form is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purchases.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal Representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I herby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I give permission for (Child's Name)_____
to participate in *Girl Scouts of Nassau County's Summer Adventures Troop Camping Program.*

I shall allow my child to attend only if she is in good physical condition at the time of her departure. I shall be responsible for meeting my child on time at the place of return.

Signature of parent or guardian_____

Printed Name_____ Date_____

**If for any religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

(Continued on reverse)

Name of family physician_____Phone_____

Address_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

___This person **takes NO medications** on a routine basis (Attach additional pages for more medications)

OR

___This person **takes medications** as follows

Med #1_____Dosage_____

Specific times taken each day_____

Reason for taking_____

Med #2_____Dosage_____

Specific times taken each day_____

Reason for taking_____

Identify any medications taken during the school year that participant does/may not take during the summer:_____

_____

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: ___Red meat ___Pork ___Dairy products ___Poultry ___Seafood ___ Eggs ___Other (Describe)_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)_____

_____

ALLERGIES List all known medication allergies, food allergies and all other allergies. Include insect stings, hay fever, asthma, animal dander, etc.

Describe reaction and management of the reaction.

_____ _____

_____ _____

Which of the following has the participant had?

___Measles
___Chicken pox
___German measles
___Mumps
___Hepatitis A
___Hepatitis B
___Hepatitis C

TB Mantoux Test
Date of last test_____ **Result:** ___Positive ___Negative

Please give all dates of immunization for:

Vaccine:	**Dates:**	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____				
	Or Measles	_____	_____				
	Or Mumps	_____	_____				
	Or Rubella	_____	_____				
Haemophilus Influenza B		_____	_____	_____	_____	_____	
Hepatitis B		_____	_____	_____			
Varicella (chicken pox)		_____	_____				

Use this space to provide any other special information (health concerns or special situations) that would make your child's stay with us easier:_____

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Use this space to provide any additional information about the participants behavior and physical, emotional, or mental health about which the camp should be aware. _____

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