# Health History Form

girl scouts of ohio's heartland

| **Personal Information** | | |
|---|---|---|
| Full Name: | | |
| Permanent Address: | | |
| Birth Date: | Age: | Sex: ☐Female ☐Male |
| **Custodial Care Information**– required only for those under the age of 18 | | |
| This person is under the custodial care of (CHECK ONE and list below as primary emergency contact): | | |
| ☐ Both Parents ☐ Mother only ☐ Father Only ☐ Other – Name & Relationship: | | |
| **Emergency Contacts** | | |
| PRIMARY CONTACT Name: | | Relationship: |
| Home Phone: | Work Phone: | Cell: |
| Address: | | |
| SECONDARY CONTACT Name: | | Relationship: |
| Work Phone: | Work Phone: | Cell: |
| Address: | | |
| **Insurance Information** | | |
| Is this person covered by medical/hospital insurance? ☐ YES ☐ NO | | |
| If yes–carrier/plan name: | Group# | |
| Carrier Address: | | |
| Name of Insured: | | |
| Policy holder's insurance policy ID# | | |

**Health History**– This information will provide healthcare personnel with the background to provide appropriate care.

**Allergies**
List all known (medications, food, insect stings, hay fever, etc.) and describe reaction and management of the reaction.

1)

2)

3)

**Medications**
List all medications, including over-the-counter drugs, taken routinely. (Required for campers and staff under the age of 18, otherwise disclosure is optional.) If no meds are taken, list NONE instead of leaving blanks. Bring medication in the original container with its prescription or over-the-counter label.

ALL medications must be turned in and administered at the camp health center. (Regardless of age.)

Please attach a signed additional sheet if more space is needed.

| | Med #1 | Med #2 | Med #3 |
|---|---|---|---|
| Name | | | |
| Dosage | | | |
| Times taken each day | ❑ Breakfast<br>❑ Lunch<br>❑ Dinner<br>❑ Bedtime<br>❑ Other: | ❑ Breakfast<br>❑ Lunch<br>❑ Dinner<br>❑ Bedtime<br>❑ Other: | ❑ Breakfast<br>❑ Lunch<br>❑ Dinner<br>❑ Bedtime<br>❑ Other: |
| Reason for taking | | | |

**For Adult Staff Only:** I ❑ DO ❑ DO NOT have medication that I have chosen not to disclose. I ❑ DO ❑ DO NOT take medication that may limit my ability to perform my basic job functions. I understand that all medications must be stored in the health center, regardless of whether they are listed on this sheet. I also understand that I must speak to the camp healthcare provider if any of my medications may limit my ability to perform essential job duties or if I need access to my medications outside normal med times.

| General Health Information | | | | | |
|---|---|---|---|---|---|
| Have you/do you... | Yes | No | Have you/do you... | Yes | No |
| 1. Had recent injury, illness/infectious disease? | | | 19. Brought an orthodontic appliance to camp? | | |
| 2. Have a chronic or recurring illness/condition? | | | 20. Have any skin problems (itching, rash, etc)? | | |
| 3. Ever been hospitalized? | | | 21. Have diabetes? | | |
| 4. Ever had surgery? | | | 22. Have asthma? | | |
| 5. Have frequent headaches? | | | 23. Had mononucleosis in the past 12 months? | | |
| 6. Ever had a head injury? | | | 24. Had problems with diarrhea/constipation? | | |
| 7. Ever been knocked unconscious? | | | 25. Have problems with sleepwalking? | | |
| 8. Wear glasses, contacts, or protective eye wear? | | | 26. Have an abnormal menstrual history? | | |
| 9. Ever had frequent ear infections? | | | 27. Have a history of bedwetting? | | |
| 10. Ever passed out during or after exercise? | | | 28. Have an eating disorder? | | |
| 11. Ever been dizzy during or after exercise? | | | 29. Have behavioral challenges (ADD, other)? | | |
| 12. Ever had seizures? | | | 30. Had measles? | | |
| 13. Ever had chest pain during or after exercise? | | | 31. Had mumps? | | |
| 14. Ever had high blood pressure? | | | 32. Had chicken pox? | | |
| 15. Ever been diagnosed with a heart murmur? | | | 33. Had hepatitis? | | |
| 16. Ever had back problems? | | | 34. Had German measles? | | |
| 17. Ever had joint problems (knees, ankles, etc)? | | | 35. Had lice, ringworm, or scabies in the past 2 months? | | |
| 18. Have an emotional health concern that may impact participation? | | | 36. Had a significant life event that continues to affect their life / health. | | |
| If you answered yes to any question, please explain, noting the item number being referenced. Add an additional sheet, if necessary. | | | | | |

| Immunizations | | | |
|---|---|---|---|
| | Date | | Date |
| DPT | | TD (tetanus/diphtheria) | |
| Polio | | MMR (Measles/Mumps) | |
| Varicella (chicken pox) | | Tetanus | |
| Hepatitis B | | Haemophilus influenza B | |
| TB Mantoux test | | | |

| Doctor Information | |
|---|---|
| Date of last physical exam (include year): | |
| Primary Care Physician: | Phone: |
| Dentist/Orthodontist: | Phone: |

| Special Dietary Restrictions | | | | |
|---|---|---|---|---|
| The following dietary restrictions apply to this individual. (Circle) | vegetarian | vegan | gluten-free | other: |
| | Kosher | no pork | lactose/dairy-free | |

| Special Activity Restrictions | |
|---|---|
| Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary). | |

**Permission for Basic Medical Treatment**– required only for those under the age of 18

By checking off the following items, I (parent/guardian) hereby give permission for the camp's designated first aider to administer the marked over-the-counter medications or generic equivalents if the onsite health care staff deems it necessary. Dosages will be administered according to directions on the product. **Mark through medications that you do not wish the camp to administer.**

| | |
|---|---|
| ☐ Acetaminophen/Tylenol – headache, menstrual cramps, muscle cramps, fever | ☐ Ibuprofen – headache, menstrual cramps, muscle cramps, fever, ear aches |
| ☐ Tecnu/Ivy Dry/Calamine lotion – poison ivy, bug bites | ☐ Cough drops/Chloraseptic spray – sore throat, cough |
| ☐ Pepto-Bismol/Tums/Rolaids – upset stomach, diarrhea | ☐ Benadryl liquid or lotion – insect bites, allergy symptoms |
| ☐ Antibiotic Cream/Neosporin – skin abrasions, minor cuts | ☐ Talcum Powder/Baby Powder – skin irritations, heat rash |
| ☐ Sudafed liquid or tablets - stuffy nose | ☐ Robitussin DM – cough |
| ☐ Claritin, Claritin D, Allegra – allergy symptoms | ☐ Hydrocortisone cream – insect bites, sunburn |
| ☐ Foille/Solarcaine/Aloe Vera Gel – sunburn | ☐ Desitin – skin irritations, heat rash |

**Acknowledgment and Consent**

This health history is correct and accurately reflects the health status of the individual to whom it pertains. The person described has permission to participate in all camp activities except as noted. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations.

If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for this individual.

I understand the information on this form will be shared on a "need to k now" basis with camp staff. I give my permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

In the event I cannot be reached in an emergency, I hereby 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 authorize the camp personnel to store and administer the medications listed on this form, as well as any included on a signed additional sheet, while in attendance at camp. Additionally, I authorize the camp's designated first aider to administer the over-the-counter medications that I have indicated on this form.


Signature (Signature of Custodial Parent / Guardian if under 18): _____

Printed Name: _____ Date: _____

**If religious beliefs prevent you from completing or signing this form, please fill out the general information, include a parent guardian statement confirming that the participant is in good health, and attach a signed letter from your place of worship indicating membership in the religious group specified.**


The Physical Exam Form is only required for participants in certain high adventure programs. Refer to the Parent Handbook for a list of camp sessions requiring this form to be completed.

# Physical Examination Form

To be completed by a licensed medical professional within twelve (12) months of attending camp.

## Basic Information

| Name: | | Birthdate: |
|---|---|---|
| Physical Exam Done Today? ❑ Yes ❑ No | If no, when was last physical: | |
| Weight: | Height: | Blood Pressure: |

## Allergies

❑ No known allergies

❑ To foods (list):

❑ To medications (list):

❑ To environment (list):

❑ Other allergies (list):

## Diet/Nutrition:

❑ Eats a regular diet

❑ Has a medically prescribed meal plan or dietary restrictions as described:

## Medications

❑ No prescribed medications

❑ Is taking the following prescribed medication(s) (name, dosage, frequency):

## Current Medical Condition/Other Treatments

❑ No current medical treatments

❑ Is currently undergoing treatment for the following conditions as described:

## Participation Recommendation

Do you feel that the participant will require limitations or restrictions to activity while at camp? ❑ Yes ❑ No

If you answered yes, please tell us your recommendation (attach additional information if needed).

## Physician Acknowledgement and Information

I have reviewed the HEALTH HIISTORY FORM and have discussed the camp program with the participant/ participant's parent or guardian. It is my opinion that the participant is physically and emotionally fit to participate in active camp programs (except as noted above).

| Name of Licensed Provider: | Signature: |
|---|---|

Office Address:

| Street | City | State | Zip Code |
|---|---|---|---|

| Office Telephone: | Date: |
|---|---|