girl scouts of eastern missouri

RESIDENT CAMP CAMPER HEALTH FORM

Due June 2

- Resident Camp - Complete entire form. Resident Campers must have a physical examination wtihin 24 months of the date of the camp session. Return to: Girl Scouts of Eastern Missouri, 2300 Ball Drive, St. Louis, MO 63146
- Parents - Complete sections 1 and 2 prior to physician's visit
- Physician - Complete section 3

Questions? Call 314.592.2300 or 800.727.GIRL (4475)

SECTION 1

CAMPER

Name: _____
First Middle Last

Address: _____
Street

_____
City State ZIP

Age: Birth Date: / / Sex: F M

Home Phone: _____

INSURANCE INFORMATION

(If participant is covered by another provider, complete the following:)

Name of Company: _____

Address: _____
Street

_____
City State ZIP

Policy or Certificate Number: _____

HEALTH HISTORY (Check all that apply)

My daugher has menstruated: ☐ yes ☐ no

If no, has she been told what to expect? ☐ yes ☐ no

Please describe conditions and give dates:
(Attach an additional sheet if necessary)

Operations or serious injuries _____

Hospitalizations _____

Other diseases/disabilities _____

Comment where applicable:

- ☐ Fainting _____
- ☐ Bed wetting _____
- ☐ Motion sickness _____
- ☐ Constipation _____
- ☐ Nosebleeds _____
- ☐ Wears contacts/glasses _____
- ☐ Hearing impairment _____
- ☐ Sleep disturbances _____
- ☐ Sickle cell trait or disease _____
- ☐ Emotional disturbances _____
- ☐ Homesickness _____

Diseases:

- ☐ Chicken Pox
- ☐ Measles
- ☐ German Measles
- ☐ Mumps

Allergies:

- ☐ Animals
- ☐ Food
- ☐ Hay Fever
- ☐ Insects
- ☐ Medicine/Drugs
- ☐ Plants
- ☐ Pollen
- ☐ Other: (specify) _____

Chronic or Recurring Illness:

- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Seizures
- ☐ Bleeding Disorders
- ☐ Asthma
- ☐ Hypertension
- ☐ Diabetes
- ☐ Musculoskeletal Disorders
- ☐ Other: (specify) _____

Specific activities to be restricted _____

Specific activities to be encouraged _____

Special medical or dietary regimen to be followed
(specify - include vegetarian diets, etc.) _____

Please indicated which over-the-counter medications and preparations may be dispensed to your daughter on an as-needed basis. All over-the-counter medications and preparations listed below will be provided and will be dispensed by the designated First Aider or Health Staff member per outlined camp physician's protocols:

Medication	Initials
☐ Acetaminophen (Tylenol)	_____
☐ Ibuprofen (Advil)	_____
☐ Sunburn preparation	_____
☐ Indigestion/diarrhea medication	_____
☐ Earache medication	_____
☐ Sore throat medication	_____
☐ Cold/cough/allergy medication	_____
☐ Calamine/Caladryl	_____
☐ Benadryl	_____
☐ Skin cleansing agent	_____
☐ Topical antibiotic	_____
☐ Eye/ear irrigation solution	_____

SECTION 2

RECORD OF IMMUNIZATION

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P.	_____	_____
Diphtheria	_____	_____
Pertussis (Whooping Cough)	_____	_____
Tetanus (must be within last 10 years)	_____	_____
Td	_____	_____
Oral Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hep B	_____	_____
Pneumococcal Conjugate Vaccine (PCV)		
Tuberculin test given (most recently)	Date: _____	Result: _____

Other: _____

_____
Name of Dentist Phone

Licensed Physician's Name: _____
First Last

Address: _____
Street

_____
City State ZIP

Phone: _____

SECTION 3

LICENSED PHYSICIAN'S HEALTH EXAMINATION

Date of Examination: ___/___/_____

Height: Weight: B.P.

Appearance - Nutrition: _____

	Without Glasses	With Glasses
Eyes	R 20/_____ L 20/_____	R 20/_____ L 20/_____
Hearing	R _____ L _____	
Code	☐ Satisfactory ☐ Unsatisfactory ☐ Not Examined	

Ears _____

Nose _____ Abdomen _____ General physical & emotional status _____

Throat _____ Genitalia _____

Teeth _____ Hernia _____ Lungs _____

Heart _____ Urinalysis* _____ HGB* _____

* Not required for every health examination. Girls ages 6-11 should have had this test upon entering school. Girls ages 12-18 should have this test if they have not had it since entering puberty.

Licensed physician's comments and recommendations: (Give details or indicate management of significant illness) _____

This person is in satisfactory condition and may engage in all usual activities except as noted.

Licensed Physician's Signature: _____

Date signed: _____

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Resident Camp Camper Health History

Due June 2

Camper's Name: _____
Last First

Buddy Request: _____
List ONE buddy only. Buddies must list each other.

Camp: ☐ Cedarledge ☐ Tuckaho

Session Name: _____

Custodial Information:
Who has custody of camper during camp session?

☐ Both Parents ☐ Mother only ☐ Father only ☐ Other: _____

Mother's/Legal Guardian's Name: _____
First Last

Address: _____

Day Phone: _____

Evening Phone: _____

Cell Phone: _____

Father's/Legal Guardian's Name: _____
First Last

Address: _____

Day Phone: _____

Evening Phone: _____

Cell Phone: _____

Name of Emergency Contact (If custodial parents/legal guardian can't be reached) _____

Address: _____

Relationship to Camper: _____

Day Phone: _____

Evening Phone: _____

Cell Phone: _____

I understand the above information will be shared only with my daughter's counselors and the camp administration. The camp staff will make every effort to protect personal health information and will only disclose such information to health care professionals providing treatment.

_____
Signature of Custodial Parent/Legal Guardian **Date**

This health history is correct and my daughter has permission to engage in all prescribed activities, except as noted by me and the licensed physician. The Girl Scouts of Eastern Missouri has my permission to treat and/or transport my daughter to the hospital or doctor for medical treatment should there be an illness or injury.

_____
Signature of Custodial Parent/Legal Guardian **Date**

I, being a parent/guardian of _____ hereby consent to Girl Scouts of Eastern Missouri (GSEM) or its designee taking photographs, digital images, film, video and/or audio or other recordings of my daughter while registered as a Girl Scout and authorize GSEM, Girl Scouts of the USA (GSUSA) and their assignees or successors to use them in telling the Girl Scout story. This may include use in GSEM/GSUSA publications, websites, events and print and electronic media. Furthermore, I agree and consent that such photographs, electronic images, video and/or audio recordings shall be the property of GSEM, which has the right to duplicate, reproduce and make other uses of the images/recordings in the best interest of Girl Scouting and GSEM, free and clear of any claim whatsoever from _____ and from me. If I wish to change this current agreement, I understand I must notify GSEM in writing.

_____
Signature of Custodial Parent/Legal Guardian **Date**

Camper's favorite foods, interests, hobbies, pets: _____

Camper eats: ☐ moderately ☐ much ☐ little ☐ often

Describe food allergies or dietary restrictions:
(such as diabetic, vegetarian, etc.) _____

Has camper been to overnight camp more than two days?
☐ yes ☐ no
If yes, where and how long? _____

Describe camper's prevoius camp experience: (day, troop or resident camp, camping with other groups/family. etc.) Attach additional sheet if needed. _____

Briefly describe camper's responsibilities at home: _____

Does camper make friends: ☐ easily ☐ fairly easily ☐ with difficulty ☐ with own age ☐ with older children

Is camper afraid of: ☐ the dark ☐ animals ☐ water ☐ other fears _____

What disciplinary method is most effective for your child? _____

Sleep habits: ☐ light ☐ heavy ☐ sleep walker ☐ nightmares ☐ other _____

Describe any past illness or disability that might limit her activity: _____

Describe and give special instructions on allergies, medical conditions or emotional conditions we should be aware of in the interest of her safety: _____

Describe personal experience(s) camper has dealt with in the past year which may affect her behavior at camp:
(such as death of a relative, divorce, school problem, loss of a pet, etc.) _____

Additional comments: _____