girl scouts of eastern missouri

2013 RESIDENT CAMP STAFF HEALTH FORM

DUE MAY 23. Questions? Call 314.592.2300 or 800.727.GIRL (4475)

Resident Camp – Complete entire form. All Resident Camp Staff must have a physical examination within 12 months of the camp sessions' date.
Return to: Girl Scouts of Eastern Missouri, 2300 Ball Drive, St. Louis, MO 63146
Staff – Complete Sections 1 and 2 prior to physician's visit. **Physician** – Complete Section 3

GINA Safe Harbor Language
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits those covered by GINA Title II from requesting or requiring genetic information of an individual or their family members, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' includes an individual's family medical history, the results of genetic tests, the fact that an individual or their family members sought or received genetic services, and genetic information of a fetus or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECTION 1

Name: _____
First Middle Last

Address: _____
Street

_____
City State ZIP

Age: Birth Date: Sex: F M

Home Phone: _____

Cell Phone: _____

Camp: ☐ Cedarledge ☐ Tuckaho

INSURANCE INFORMATION
Name of Company: _____
First Middle Last

Address: _____
Street

_____
City State Zip

Policy or Certificate Number: _____

HEALTH HISTORY (Check all that apply)
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 _____

Specific activities to be restricted: _____

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): _____

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

Please indicate which over-the-counter medications and preparations maybe dispensed to you or your daugher (if minor staff member or Aide) 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	Years Primary Series Completed	Year of Last Booster
DTP		
Diptheria	_____	_____
Pertussis (Whopping Cough)	_____	_____
Tetanus	_____	_____
TD	_____	_____
Oral Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hep B	_____	_____
Pneumococcal Conjugate Vaccine	_____	_____

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: _____

*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.

Nose _____ Abdomen _____ General Physical
Throat _____ Genitalia _____ & Emotional Status _____
Teeth _____ Hernia _____ Lungs _____
Heart _____ Urinalysis* _____ HGB* _____

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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EMERGENCY CONTACT
Contact #1

Name: _____
First Middle Last

Relationship: _____

Address: _____
Street City State Zip

Day Phone: _____

Evening Phone: _____

Cell Phone: _____

Contact #2

Name: _____
First Middle Last

Relationship: _____

Address: _____
Street City State Zip

Day Phone: _____

Evening Phone: _____

Cell Phone: _____

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

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

Additional Comments: _____

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

Staff Signature _____ Date _____

If Minor, Custodial Parent's or Legal Guardian's Signature _____ Date _____

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

Staff Signature _____ Date _____

If Minor, Custodial Parent's or Legal Guardian's Signature _____ Date _____

I, _____, hereby consent to Girl Scouts of Eastern Missouri (GSEM) or its designee taking photographs, digital images, film, video and/or audio recordings of me 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, Web sites, 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 me. If I wish to change this current agreement, I understand I must notify GSEM in writing.

Staff Signature _____ Date _____

If Minor, Custodial Parent's or Legal Guardian's Signature _____ Date _____