Last Name: **First Name:**

Nickname (if any):_____

Age _____ Birth date _____

Parent/Guardian_____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ e-mail _____

Home Address _____

City _____ State _____ Zip Code _____

Health Insurance –

Is the participant covered by family medical insurance? ☐ yes ☐ no

Insurance Carrier or Plan Name _____

Group # _____

Health History (please explain "yes" answers below.)

Has / does the participant:	Yes	No		Yes	No
1. Had a recent injury, illness	☐	☐	12. Have diabetes?	☐	☐
or infectious disease?			13. Have asthma?	☐	☐
2. Have a chronic or recurring	☐	☐	14. Problem with	☐	☐
Illness or condition?			stomach, diarrhea, or constipation?		
3. Ever been hospitalized?	☐	☐	15. Sleepwalk?	☐	☐
4. Ever had surgery?	☐	☐	16. History of bedwetting?	☐	☐
5. Have frequent headaches?	☐	☐	17. Eating disorder?	☐	☐
6. Ever had a head injury?	☐	☐	18. Emotional difficulties?	☐	☐
7. Ever been unconscious?	☐	☐	19. Attention issues?	☐	☐
8. Frequent ear infections?	☐	☐	20. Anxiety issues?	☐	☐
9. Ever had seizures?	☐	☐	21. Knee/hip/back	☐	☐
10. Have high blood pressure?	☐	☐	or other joint/bone issues?		
11. History of nosebleeds?	☐	☐	22. Anything else?	☐	☐

Health History, Continued:

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

Please attach additional pages if needed for further explanation.

Medication Allergies (list)	Describe reaction & management of reaction
_____	_____
_____	_____
_____	_____
_____	_____
Food Allergies (list)	Describe reaction & management of reaction
_____	_____
_____	_____
_____	_____
_____	_____
Other Allergies (list)	Describe reaction & management of reaction
_____	_____
_____	_____
_____	_____
_____	_____

Medications Will the camper be bringing medications to camp? ☐ No ☐ Yes
This person takes medications as follows: (include prescription and over-the-counter)

Med #1 _____ Dosage/times per day: _____

Reason for taking _____

Med #2 _____ Dosage/times per day: _____

Reason for taking _____

Please attach additional pages for more medications. Both over-the-counter and prescription meds to be administered at camp must be in the original pharmacy-labeled containers with the patient's name, dosage, time of administration, and any special instructions clearly stated. Please, only one medication per container.

For Campers - has she menstruated? ☐ Yes ☐ No

If she has not begun menstruating, does she know about it? _____

Please List Any Other Special Considerations or Concerns:

_____

_____

_____

Parent / Guardian Notification Policy

On rare occasions, due to health or safety concerns, campers are unable to complete the full camp program. If any of the following situations occur, a parent/guardian will be contacted, and the appropriate measures will be taken.

- ☐ A camper with a fever over 100 degrees
- ☐ A camper who comes down with a communicable disease
- ☐ A camper who is excessively sick with a condition or illness that we cannot manage at camp
- ☐ A camper who is taken to urgent care or the emergency room
- ☐ A camper who is a danger to herself and/or to others

Non-Prescription Medication Permission

I hereby grant permission to dispense the following over-the-counter medications.

Signature _____ Date _____

Camper's height: _____ Camper's Weight: _____

Please check all medications that we have permission to dispense to your daughter and note any special instructions.
We calculate dosage by weight so please be accurate with your daughter's information.

- ☐ Acetaminophen – generic Tylenol (aches and pain) _____
- ☐ Aloe Vera Gel (sunburn) _____
- ☐ Benadryl – cream / tablets (stings, bites, allergies) _____
- ☐ Celox / Bleed Cease (for stopping serious nosebleeds) _____
- ☐ Hydrocortisone Cream – Cortaid generic (itching) _____
- ☐ Hydrogen Peroxide – cleaning wounds / antiseptic _____
- ☐ Ibuprofen – generic Advil (minor aches, pain, cramps) _____
- ☐ Imodium AD/generic (diarrhea) _____
- ☐ Ocean Nasal Mist (saline, for nosebleeds) _____
- ☐ Neosporin antibiotic ointment (minor scrapes, cuts) _____
- ☐ Sterile saline eye wash (sand in eyes, etc.) _____
- ☐ Vaseline (nosebleeds) _____

Please list any medication or dietary concerns:

_____

_____

Authorization & Permission to Provide Necessary Treatment or Emergency Care:
The undersigned do hereby authorize the officers, leaders or agents of Girl Scouts of Greater Los Angeles, to consent to any x-ray examination, anesthetic, medical or surgical treatment and hospital care to be rendered to said minor under the general or special supervision and upon the advice of a physician or surgeon licensed under the provisions of the Medical Practice Act, or to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act. It is further understood that permission is hereby granted to the officers, leaders or agents of Girl Scouts of Greater Los Angeles to obtain and administer such medical aid or assistance as might, in their judgment, be required for the immediate care of your daughter. In the event of such help, Girl Scouts of Greater Los Angeles, its officers, leaders and agents will not be held liable for any first aid treatment or hospital care rendered drugs, medicine or surgical procedures performed pursuant to this consent. This consent supersedes all prior authorization.

Signature of Parent / Guardian _____ Date _____