Resident Camp - Health Form

(Camps Hidden Lake & Lake Clear)

girl scouts of northeastern new york

REMEMBER – Health History Form Must be Received by June 15th

Parents/Guardians: Your daughters' health form must be received by our Albany office on or before June 15th. Without this form your daughter cannot stay at camp. Please PRINT clearly and include area code with phone numbers. Parents/Guardians please sign, complete and send to:

Albany Service Center, 8 Mountain View Ave., Albany, NY 12205, Fax: (518) 489-8065

Camper's Name: _____ Nickname: _____

Camp Program: _____ Session: _____

Camp Program: _____ Session: _____

Camp Program: _____ Session: _____

EMERGENCY CONTACT INFORMATION (PLEASE PRINT)

Camper's Name:		Date of Birth:	Age:
Address:			
City:		State:	Zip:
Home Phone:	Cell Phone:	Email:	

Parent/Guardian (1)			
Address: (if different from the camper's)			
City:		State:	Zip:
Home Phone:	Cell Phone:	Email:	

Parent/Guardian (2)			
Address: (if different from the camper's)			
City:		State:	Zip:
Home Phone:	Cell Phone:	Email:	

If parent/guardian is unavailable, notify:		Relationship:	
Address:			
City:		State:	Zip:
Home Phone:	Cell Phone:	Email:	

Name of child's physician:	Phone:
Primary insurance carrier:	Policy or group #:
Subscriber:	Insurance Company Phone #:

EMERGENCY MEDICAL AUTHORIZATION

In the event, reasonable attempts to contact me or the emergency contacts at the above listed phone numbers have been unsuccessful, I hereby give GSNENY staff my consent to transport my child to an accessible hospital facility, and for administration of emergency medical treatment by any licensed physician**,** midlevel provider under physician direction, or dentist to order x-rays, routine tests, secure proper treatment for, order injection, anesthesia, or surgery for my child.

I understand I am responsible for the cost of medical care. To my knowledge, the health form is correct and my child has permission to engage in all camp activities except as noted by me and or her physician.

I also give permission to photocopy this form for out of camp trips and I understand the information on this form will be shared on a "need to know" basis with camp staff.

Parent/Guardian Signature: _____ **Date:** _____

CAMPER'S PHYSICAL ISSUES + IMMUNIZATIONS: THIS SECTION TO BE COMPLETED BY PARENT

ILLNESSES AND INJURIES
(Check those chronic or recurring illnesses that apply and give appropriate dates)

- ☐ Ear Infections _____
- ☐ Heart Disease/Defect _____
- ☐ Bleeding/Clotting Disorders _____
- ☐ Musculoskeletal Disorders _____
- ☐ Asthma _____
- ☐ Seizures _____
- ☐ Rubella _____
- ☐ Rheumatic Fever _____
- ☐ Chicken Pox _____
- ☐ Measles _____
- ☐ Mumps _____
- ☐ Operations/Serious Injuries _____
- ☐ Diabetes _____

ALLERGIES
(Check those that apply and specify nature of allergic reaction)

- ☐ Animals _____
- ☐ Pollen _____
- ☐ Medicine/Drugs _____
- ☐ Plants _____
- ☐ Hay Fever _____
- ☐ Food _____
- ☐ Insect Stings _____
- ☐ Other: _____

_____

In order for your daughter to stay at camp the New York State Health Department requires that the Immunization History be filled out completely with dates.

OTHER HEALTH CONDITIONS
(Check those that apply and add comments if applicable)

- ☐ Bed Wetting _____
- ☐ Constipation _____
- ☐ Hearing Impairment _____
- ☐ Sickle Cell Disease _____
- ☐ Special Dietary regimen _____
- ☐ Wears glasses/contact lenses _____
- ☐ Emotional Disorder _____
- ☐ ADD/ADHD _____
- ☐ Fainting _____
- ☐ Menstrual Cramps _____
- ☐ Motion Sickness _____
- ☐ Nose Bleeds _____
- ☐ Sleep Disturbances _____
- ☐ Restricted Activity: _____
- ☐ Headaches _____

IMMUNIZATION HISTORY

Immunization	Year primary series completed	Year of last booster
DPT		
Tetanus/Diphtheria		
Tetanus (most recent)		
Oral Polio		
Injectable Polio		
Measles		
Rubella		
Mumps		
T.B. Test		
Hep B		
Hib		
Varicella		
Menactra		
Other:		

CAMPER'S SPECIAL NEEDS: THIS SECTION TO BE COMPLETED BY PARENT (PLEASE PRINT)

Parent/guardians sign below authorizing her use of Bug Spray & Sunscreen lotion while at camp…

Bug Spray	Signature:	Date:
Suntan lotion	Signature:	Date:

Does your daughter experience any of the following?

☐ Homesickness ☐ Headaches ☐ Constipation ☐ Nose bleeds ☐ Bedwetting
☐ Sleep walking ☐ Nightmares ☐ Other: _____

Will a sibling be at camp? ☐ Yes ☐ No

Does your daughter eat a regular diet? ☐ Yes ☐ No

Does your daughter eat a regular vegetarian/vegan diet? ☐ Yes ☐ No

Does your daughter have special food needs? ***(Please describe below.)*** ☐ Yes ☐ No

Does your daughter have any food allergies? ***(Please describe below.)*** ☐ Yes ☐ No

Has there been any recent events in your child's life (ex: death of a family member or pet) that may be concerning your child. **Please explain:**

Does your daughter have any restrictions while at camp? ☐ Yes ☐ No
Please explain:

Are there any other concerns you would like to share?

MEDICAL EXAMINATION: THIS SECTION TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT)

This Medical Examination to be completed by a licensed physician. This exam must be performed within 24 months of a child's arrival at camp. This is in compliance with NYSDOH.

Was a physical exam conducted today ☐ Yes ☐ No If no, date of last physical _____.
month, date, year

Height		Abdomen	
Weight (in kg)		G/U	
Blood Pressure		Extremities - M/S	
HEENT:		Neuro	
Heart		Skin	
Lungs		Spine	

Has this child menstruated? ☐ Yes ☐ No
If not, has she been told about menstruation? ☐ Yes ☐ No

Is this child under a physician's care for any reason? ☐ Yes ☐ No
(If yes, please specify)

_____

_____

Is this child under a psychologist's care? ☐ Yes ☐ No

_____

_____

Does your child have a developmental disability and is under care of a doctor? ☐ Yes ☐ No
If yes, does your child have a treatment, care or behavioral plan? ☐ Yes ☐ No
If yes, please submit a copy of your child's plan.

Are any prescribed medications not being taken during the summer months? ☐ Yes ☐ No
(If yes, please specify)

_____

_____

_____

Does the child have a self-carry physicians statement for_____?

Epi-Pen	☐ Yes ☐ No	Glucometers	☐ Yes ☐ No
Inhaler	☐ Yes ☐ No	Snacks	☐ Yes ☐ No

I have examined the individual described and reviewed her health history. This individual is in satisfactory health, free from communicable diseases, and able to participate in camp activities.

Examining Physician Signature: _____

Address: _____

City/State/Zip: _____

Phone: _____ Date: _____

MEDICATIONS AT CAMP: THIS SECTION TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT)

STANDARD OVER THE COUNTER/PRN MEDICATIONS (The following medications are available in the infirmary and will be administered at the discretion of our health supervisor, if approval is indicated by the child's health care provider.)

Drug Name	Dosage	Route	Schedule & Indications	Healthcare Provider Approval	Comments
Aloe			Every____hours prn	☐ Yes ☐ No	
Benadryl			Every____hours prn	☐ Yes ☐ No	
Calamine Lotion			Every____hours prn	☐ Yes ☐ No	
Chloraseptic (Sore Throat Spray)			Every____hours prn	☐ Yes ☐ No	
Claritin			Every____hours prn	☐ Yes ☐ No	
Generic Cough Drops			Every____hours prn	☐ Yes ☐ No	
Hydrocortisone			Every____hours prn	☐ Yes ☐ No	
Kaopectate/Pepto-Bismol			Every____hours prn	☐ Yes ☐ No	
Mineral Oil			Every____hours prn	☐ Yes ☐ No	
Motrin			Every____hours prn	☐ Yes ☐ No	
Robitussin Syrup			Every____hours prn	☐ Yes ☐ No	
Saline Eye			Every____hours prn	☐ Yes ☐ No	
Sudafed			Every____hours prn	☐ Yes ☐ No	
Swimmers Ear			Every____hours prn	☐ Yes ☐ No	
Tums/Maalox			Every____hours prn	☐ Yes ☐ No	
Tylenol			Every____hours prn	☐ Yes ☐ No	
Other (epi-pen?)			Every____hours prn	☐ Yes ☐ No	

PRESCRIPTION MEDICATIONS (Please complete the patient's current regimen for both scheduled and PRN medications – attach additional information if necessary).

MEDICATIONS MUST BE SENT TO CAMP IN THEIR ORIGINAL PHARMACY CONTAINERS WITH CAMPERS NAME ON THEM.

Drug Name	Dosage	Route	Schedule & Indications	Healthcare Provider Approval	Comments

Physician's Name: _____

Physician's Signature: _____

Office Number: _____ **License Number:** _____