

Please type or write clearly and legibly.

<p>Girl Scouts of Greater Los Angeles Camper Health History Page 1 (parents/guardians complete)</p>	<p>Dates will attend camp: ____/____/____ to ____/____/____ Month Day Year Month Day Year</p> <p>Camper Name: _____ First Name Middle Last</p> <p>Birth Date: ____/____/____ Age on arrival at camp ____ Month Day Year</p>
<p><b>This form (and medication in original containers) must accompany your camper directly to camp or to camp bus stop. Forms and medication should be placed in a large, clear zip-top bag with camper's name clearly labeled.</b></p>	<p>Parents/Guardians: 1. Please complete pages 1, 2 and 3 of this form (Camper Health History). 2. Complete the top of page 4 (Medical Examination) and provide all 4 pages to your child's health care provider for review (pages 1-3) and completion (page 4). 3. After page 4 has been completed and signed by medical personnel, please bring all 4 pages with your camper to camp or the camp bus stop.</p>

**Camper Information:**

Name of Minor: (Last, First, Middle Initial)	Date of Birth: (XX/XX/XXXX)		
Address:	City:	St:	Zip:

**Parent/Guardian with Legal Custody Information:**

Emergency Contact:	Relationship:		
Phone:	Alternate Phone:		

**Second Parent/Guardian or Emergency Contact Information:**

Emergency Contact:	Relationship:		
Phone:	Alternate Phone:		

**Emergency Contact Information:**

Emergency Contact:	Relationship:		
Phone:	Alternate Phone:		

**Health Insurance Information** (Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)

Policy Holder's Name:	Policy Number:		
Insurance Company Name:	Group Number:		
Insurance Company Address:	Insurance Company Phone:		

**Allergies:** Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Girl Scouts of Greater Los Angeles Camper Health History Page 2 (parents/guardians complete)	Camper Name: _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: -10px;"> <span>First Name</span> <span>Middle</span> <span>Last</span> </div> Birth Date: ____/____/____ <div style="display: flex; justify-content: space-between; font-size: x-small; margin-top: -10px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
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**Check all that apply and explain in detail checked answers:**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Musculoskeletal Disorders	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Heart Defects/Disease	<input type="checkbox"/> Convulsions/Epilepsy/Seizures	<input type="checkbox"/> Fainting
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sinusitis (Sinus Infections)	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (ADD/ADHD)	<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Physical Restrictions	<input type="checkbox"/> Mental/psychological disorder	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Kidney/bladder illness	<input type="checkbox"/> Eating Disorders (Anorexia, Bulimia, etc.)	<input type="checkbox"/> Measles
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> German Measles
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Had surgery or hospitalized in the last 5 years	<input type="checkbox"/> Mumps
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Currently under doctor's care	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Has begun menstruation	<input type="checkbox"/> Emotional – Separation Anxiety	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Other:		<input type="checkbox"/> Back/Joint Problems

**Please explain in detail all checked answers marked above:**

**Does your daughter suffer from Anaphylaxis? Yes No**

\*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

**Does your daughter carry an EpiPen? Yes No**

**Does your daughter carry an inhaler? Yes No**

**Medical Conditions (including any precautions or restrictions on activities)**

Name of Condition	Effects
1.	
2.	
3.	
4.	



Girl Scouts of Greater Los Angeles Camper Health History & Medical Exam Page 4 (Physician complete)	Camper Name: _____ <div style="display: flex; justify-content: space-between; font-size: small; margin-top: -10px;"> <span>First Name</span> <span>Middle</span> <span>Last</span> </div> Birth Date: ____/____/____ <div style="display: flex; justify-content: space-between; font-size: x-small; margin-top: -10px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
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**Medical Examination – Must be completed in detail.**

Physical exam done today?    Yes    No    (If no, date of last physical ____/____/____)    Last physical exam must be within last 24 months. <div style="display: flex; justify-content: space-around; font-size: x-small; margin-top: -10px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>			
Height: _____	Weight: _____	B. P.: _____/_____/_____	Hearing: R ____ L ____
Eyes: With Glasses R 20/____	L 20/____	Without Glasses R 20/____	L 20/____
Code: S = Satisfactory    NS = Not Satisfactory    NE = Not Examined			
____ Nose	____ Abdomen	____ Urinalysis*	Other: _____
____ Throat	____ Hernia	____ HGB*	_____
____ Teeth	____ Genitalia	____ Appearance/Nutrition	_____
____ Heart	____ Skin	____ General Physical State	_____
____ Lungs	____ Musculoskeletal	____ General Emotional State	_____

\*Girls should have this test if she had not had it since entering puberty.

**Allergies**

<input type="checkbox"/>	No Known Allergies
<input type="checkbox"/>	Food (list)
<input type="checkbox"/>	Medicine (list)
<input type="checkbox"/>	The Environment (insect stings, hay fever ect.) (list)
<input type="checkbox"/>	Other
Describe previous reactions	

**Diet/Nutrition**

<input type="checkbox"/>	This camper eats a regular diet	<input type="checkbox"/>	Has a medically prescribed meal plan or dietary restrictions (describe below).
Describe dietary restrictions			

**Treatment/Therapy**

<input type="checkbox"/>	This camper is undergoing treatment or therapy at this time for the following conditions (describe below)	<input type="checkbox"/>	None
Describe treatment			

**Medication**

<input type="checkbox"/>	No daily medications	<input type="checkbox"/>	Will take the following prescribed daily medication(s) while at camp (describe below). (Name, Dose, Frequency)

**Limitations/Restrictions at Camp**

Do you feel that the camper will require limitations or restrictions to activity while at camp?    Yes    No	
If you answered 'Yes' to the question above, what do you recommend? (describe below – attach additional information if needed)	

**Physician Information**

<b>Licensed Physician Name:</b> (Last, First, Middle Initial)	<b>Phone Number:</b>		
<b>Address:</b>	<b>City:</b>	<b>St:</b>	<b>Zip:</b>

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

**Signature of Licensed Physician:** \_\_\_\_\_    **State License Number:** \_\_\_\_\_    **Date:** \_\_\_\_\_