



2007 HEALTH CARD

BRING THIS CARD WITH YOU TO CAMP

Girl Scouts of Eastern Iowa and Western Illinois, Inc.
Resident/Day Camp Health History and Examination Form

PLEASE SELECT ONE:

- Camper
- Staff Member
- Adult Participant

PLEASE NOTE

A complete, signed 2007 Health Card is required for **all** participants (*girl and adult*), regardless of the session or program.

Camper Name (Last, First, Initial)	Name & Relationship of parent/guardian completing this form			Daytime Phone ()		
Address (Street and Number)	City or Town	State	Zip Code	Date of Birth	Age	Grade

EMERGENCY CONTACT INFORMATION - Must include parent/guardian or person completing form.

Relationship Key: M = Mother, F = Father, SM = Stepmother, SF = Stepfather, GP = Grandparent, O = Other

NAME	RELATIONSHIP	DAYTIME PHONE	EVENING PHONE	CELL PHONE

Are there any legal custodial issues we should be aware of? No Yes If yes, please explain: _____

INSURANCE INFORMATION (Please attach a copy of your medical insurance card)

Is the participant covered by family medical/hospital insurance? Yes No

If yes, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social security number of policy holder or insurance ID number _____

Hospital Preference (if applicable) _____ CITY _____ STATE _____

HEALTH HISTORY - Must be completed by parent/guardian. Check all that apply.

CHRONIC OR RECURRING ILLNESS	OTHER HEALTH CONDITIONS	In the last year, has participant had:
<input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Kidney disease <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Sinusitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Bedwetting <input type="checkbox"/> Behavioral disturbances <input type="checkbox"/> Constipation <input type="checkbox"/> Depression <input type="checkbox"/> Diarrhea <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Fainting <input type="checkbox"/> Frequent colds <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Frequent stomach aches	<input type="checkbox"/> an injury/illness requiring medical attention <input type="checkbox"/> a surgical operation or fracture <input type="checkbox"/> restrictions from participation in p.e. class <input type="checkbox"/> an illness lasting longer than 5 days <input type="checkbox"/> hospital treatment <input type="checkbox"/> exposure to a contagious disease Is participant currently: <input type="checkbox"/> receiving psychological counseling <input type="checkbox"/> under a physician's care <input type="checkbox"/> restricted from physical activity <input type="checkbox"/> taking prescription medication <i>(Complete reverse side.)</i> <input type="checkbox"/> taking over the counter medication <i>(Complete reverse side.)</i>
OTHER INFORMATION Has your daughter been taught about menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No Has your daughter begun menstruation? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify any special dietary regimen to be followed: _____ _____ Specify activities to be encouraged: _____ Specify activities to be restricted: _____ List necessary adaptations or limitations: _____ _____		Please explain any items checked above. Give dates and include any information that would be helpful to camp staff in relation to these health conditions. Add an additional sheet if needed. _____ _____ _____

ALLERGIES List all known (medication, food, insect stings, hay fever, etc.) Describe reaction & management of the reaction.

****Attach additional pages for more allergies****

The following medications are provided at each camp. These products are recommended by our Camp Physicians through our standing orders. They will be administered under the Health Supervisor's or designee's supervision; dosage as appropriate for weight and/or age.

We encourage your permission to use them by placing an "X" in the box beside each.

- | | | | |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Antacid | <input type="checkbox"/> Antidiarrheals | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Decongestant | <input type="checkbox"/> Expectorant | <input type="checkbox"/> Diphenhydramine | <input type="checkbox"/> Ibuprofen |

Contact the Camp Director if you would like to see our Standing Orders or Health Care Plan.

PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS BROUGHT FROM HOME (Please complete below)

MEDICATION	CONDITION TREATED	DOSAGE	TIME OF DAY			TAKEN WITH FOOD?
			<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	
			<input type="checkbox"/> Bedtime	<input type="checkbox"/> As needed	<input type="checkbox"/> Other _____	
			<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	
			<input type="checkbox"/> Bedtime	<input type="checkbox"/> As needed	<input type="checkbox"/> Other _____	
			<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	
			<input type="checkbox"/> Bedtime	<input type="checkbox"/> As needed	<input type="checkbox"/> Other _____	

RECORD OF IMMUNIZATION

Date of Last Immunization _____ Date of Last Immunization _____

- | | |
|---|---|
| DTaP _____ | Diphtheria _____ |
| Pertussis (Whooping Cough) _____ | Tetanus (within last 10 years) _____ |
| Td _____ | Oral polio/IPV _____ |
| Measles _____ | Mumps _____ |
| Rubella _____ | Hib _____ |
| Hep B _____ | Tuberculin Test Year last given _____ Result _____ |

This health record, including the allergy and medicine information on this form, is complete and accurate. My daughter has my permission to engage in all prescribed activities, including strenuous activities such as hiking, swimming, climbing hills, and horseback riding (if applicable), except as noted by me and the examining physician.

I give my permission for the camp staff to obtain in-camp or out-of-camp medical treatment for my daughter should the need arise while she is at camp. In case of emergency, if none of the contacts on the opposite site of this form can be contacted, I consent to treatment for my daughter under the supervision of and as deemed advisable by a physician licensed under the Medicine Practice Act. If my daughter is out of camp on a trip, I will not be contacted before medical treatment is given.

HEALTH INFORMATION PRIVACY STATEMENT

This **Health Card** is for health care concerns at Girl Scout camp sessions only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health service supervisor at each camp. Minimal necessary information may be shared with other staff/volunteers in order to provide adequate participant safety and health care. The health card will be retained by Girl Scouts of Eastern Iowa and Western Illinois until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. I have read the above procedures for handling the health card and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

SIGNATURE OF PARENT OR GUARDIAN _____ **DATE** _____

******* PHYSICAL EXAMINATION *******

NOTE TO PHYSICIAN: Required for any individual participant attending program lasting two (2) nights or more. Day camp and adult-girl partner program participants do not need to complete the following section.

DATE OF HEALTH EXAMINATION: _____

- | | |
|-----------------|-----------------------|
| Nose _____ | Throat _____ |
| Teeth _____ | Heart _____ |
| Lungs _____ | Abdomen _____ |
| Genitalia _____ | Hernia _____ |
| Skin _____ | Musculoskeletal _____ |

General physical and emotional status _____

Urinalysis* _____ HGB* _____

Other notes

Physician's comments and/or recommendations.
Give details or indicate management or significant illnesses.

*Not required for every health exam. A girl ages 11-18 should have this test if she has not had it since entering puberty.

Height _____ Weight _____ B.P. _____
Appearance/Nutrition _____

	WITHOUT GLASSES	WITH GLASSES
EYES	R 20/ _____ L 20/ _____	R 20/ _____ L 20/ _____

EARS	Hearing Right _____	Hearing Left _____
-------------	---------------------	--------------------

Which of the following, if any, has the patient had?

- | | | |
|------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> German Measles | |

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

Licensed physician's name: _____

Licensed physician's signature: _____

Street Address _____

City _____ State _____ Zip _____

Phone () _____ Date _____