Two Rivers Day Camp - Health History Form

Please print clearly in ink – ALL FIELDS ARE REQUIRED – one form needed per person

◯ Camper ◯ Youth Staff ◯ Adult ◯ Sibling

First Name: _____ MI: ____ Last Name: _____ Troop #: _____

Custodial Care (complete if under 18) ◯ Both Parents ◯ Mother only ◯ Father only ◯ Other (please list) _____

Name of Physician/Clinic:					Phone:
Medical/Hospital Insurance Company: ☐ ✓ if none					
♦*Photocopy of front & back of Health Insurance Card must accompany this form*♦					Policy or Group #:
Dental Insurance Company: ☐ ✓ if none					Policy or Group #:
DOB:	Immunizations up to date? Yes / No				*Please list dates of all immunizations or include a copy of immunization records*
Tetanus: MM/DD/YY	Diphtheria: MM/DD/YY	Polio: MM/DD/YY	MMR: MM/DD/YY	HepB: MM/DD/YY	Chicken Pox (Varicella): MM/DD/YY
Date of Last Health Exam:		Were there any medical problems at the time? Yes ◯ No ◯ If yes, please explain:			
Does participant have any physical, mental or psychological conditions requiring medication, treatment or other special restrictions or considerations? Yes ◯ No ◯		If yes, please explain:			
Does participant take any prescribed medications or over-the-counter drugs on a regular basis? Yes ◯ No ◯ **Note** – If taking ANY medications at camp, they must be in original container & be accompanied by a medication form.		If yes, please state medication and reason:			
Is participant restricted or limited from participating in any physical activity? Yes ◯ No ◯		If yes, please explain:			
Please provide a record of past medical treatment, if any, including injuries or surgeries: ☐ None					
Participant has the following health conditions: ☐ None		☐ ADHD ☐ Asthma ☐ Diabetes ☐ Headaches ☐ Seizures ☐ Other _____ **ALLERGIES:** ☐ No Know Allergies			
Does participant have any dietary restrictions or food allergies? Yes ◯ No ◯		If yes, please explain:			

If needed, the Day Camp First Aider may give the following medications/treatments:

Tylenol/Acetaminophen	◯ Yes	◯ No	Note: **(Please list weight for children under 12)** _____
Motrin/Ibuprofen	◯ Yes	◯ No	Note: **(Please list weight for children under 12)** _____
Midol/generic	◯ Yes	◯ No	Note: _____
Orajel/generic (numbing bites & stings)	◯ Yes	◯ No	Note: _____
Saline (eye wash or wound cleaning)	◯ Yes	◯ No	Note: _____
Antibiotic cream (for cuts)	◯ Yes	◯ No	Note: _____
Bug spray	◯ Yes	◯ No	Note: _____
Sunscreen	◯ Yes	◯ No	Note: _____
Calamine Lotion/generic	◯ Yes	◯ No	Note: _____
Benadryl/generic	◯ Yes	◯ No	Note: _____
Latex Band-aids okay	◯ Yes	◯ No	Note: _____

Participant's Name: ____

MEDICATION INFORMATION – FOR ALL MEDICATIONS THAT WILL BE BROUGHT TO CAMP

MEDICATION AND DOSE:____

REASON FOR MEDICATION:____

PLEASE CHECK AS TO WHEN MEDICATION SHOULD BE GIVEN

TO BE GIVEN AS NEEDED ☐ PRESCRIBED TIMES ONLY ☐

	MON	**TUES**	**WED**	**THURS**	**FRI**	**SAT**
BREAKFAST	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	
LUNCH						NOT AT CAMP
DINNER	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP
BEDTIME	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP

MEDICATION AND DOSE:____

REASON FOR MEDICATION:____

PLEASE CHECK AS TO WHEN MEDICATION SHOULD BE GIVEN

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	MON	**TUES**	**WED**	**THURS**	**FRI**	**SAT**
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DINNER	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP
BEDTIME	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP

MEDICATION AND DOSE:____

REASON FOR MEDICATION:____

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	MON	**TUES**	**WED**	**THURS**	**FRI**	**SAT**
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LUNCH						NOT AT CAMP
DINNER	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP
BEDTIME	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP

Parent/Guardian Authorization

This health form is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my child should not participate in the prescribed activities except as noted. In the event that my child needs medical attention while participating in Girl Scout activities, I authorize the adult in charge to see that my child receives routine healthcare, medications, reasonable first aid and to transport my child to a health care facility for emergency services as needed.

Signature of parent/guardian: ________________________________ Date: ______________

Adult Authorization

This health form is complete and accurate. I am able to engage in all prescribed activities except as noted.

Signature of adult: ________________________________ Date: ______________

Make sure to include a copy (front & back) of health insurance card with Health Form