Celebrate Girls Summer Program Health History Form 2019

girl scouts of northern new jersey

Program Attending: ☐ **Celebrate Girls Paterson**

THIS HEALTH HISTORY FORM MUST BE COMPLETED BY MAY 30, 2019.
The form is to be completed and signed by the camper's parent/guardian.
A doctor's signature is NOT required for this health form.

Camper Name:

Girl Name: _____ **Date of Birth:** _____ **Age:** _____
Address: _____ **Grade in Sept. 2019:** _____
City: _____ **State:** _____ **Zip:** _____

Parent/Guardian 1 Name: _____ **Home Phone:** _____
Email (REQUIRED): _____ **Work Phone:** _____
Cell Phone: _____
Parent/Guardian 2 Name: _____ **Home Phone:** _____
Email (REQUIRED): _____ **Work Phone:** _____
Cell Phone: _____

Do both parents have custody? ☐ Yes ☐ No If no, who is the custodial parent/guardian?

_____

If a non-custodial parent is denied access to a child by a court order, you must provide camp with a copy of the documentation.

Child Release Permit
My child may be released to the following adults:

Name & Phone: _____ **Relationship:** _____
Name & Phone: _____ **Relationship:** _____

My girl has permission to walk home from Girl Scout activities un-chaperoned by an adult. **Yes** **No**

Emergency Contact (Will only be contacted if the parents/guardians are not available).
Name: _____ **Primary Phone:** _____
Relationship to Child: _____ **Seconday Phone:** _____

Name of Family Physician: _____ **Phone:** _____
Primary Insurance Carrier: _____ **Policy or Group #:** _____

General Health Date of last health examination: _____ Date of last tetanus shot: _____

Provide Most Recent Dates for All That Apply:

_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Blood Disorders
_____ Hypertension
_____ Psychiatric Treatment
_____ Mononucleosis
_____ ADHD
_____ Autism Spectrum Disorder

_____ Sickle Cell Trait/Disease
_____ Musculoskeletal Disorder
_____ Chronic or Recurrent Illness
_____ Diabetes: 1) Glucose Testing? ☐ No ☐ Yes
2) On Insulin? ☐ No ☐ Yes
3) Pump or Injection? ☐ No ☐ Yes
_____ Asthma 1) Use of Inhaler? ☐ No ☐ Yes
2) Self Administer? ☐ No ☐ Yes
_____ Seizures 1) Most recent: _____
2) Medications: _____

Allergies: Describe reaction, if known.
REQUIRED: ATTACH A COPY OF ANY ALLERGY OR ASTHMA ACTION PLAN(S) SPECIFIC TO YOUR CHILD.

Insect Stings: _____ Poison Ivy: _____
Food Allergies: _____ Hay Fever: _____
_____ Other Allergies: _____
Penicillin: _____ Prescribed Epipen? ☐ No ☐ Yes
Other Drugs: _____ Can Self Administer Epipen? ☐ No ☐ Yes

Medication taken routinely (prescription and OTC): _____

_____

Date Rec'd:

Session(s):

Can your child participate in all camp activities as described in the camp brochure?
□ Yes, she is in good health and can participate without any accommodations.
□ Yes, she can participate with reasonable accommodations in respect to health or physical special needs.
Describe: _____
□ No, she needs to be exempt from the following activities:
_____

Hospitalization / Operations / Injuries: _____

Is the camper currently under the care of a physician or psychologist? □ No □ Yes, please specify:
_____

Has she started menstruation? □ No □ Yes

Any additional information we should know about your child: _____
_____

Please feel free to attach any additional significant information that will assist us in providing an enriching day camp experience for your camper.

EMERGENCY MEDICAL AUTHORIZATION

I give consent for my child, _____, to receive medical treatment according to camp protocol written by standing orders by the camp doctor, or otherwise directed in writing by the child's physician. In the event of a known severe allergy, camp staff as per physician's instructions to prevent life-threatening conditions, will administer medication. In the event of an emergency, I give my consent for the administration of emergency medical treatment and to transport the child to hospital facilities if necessary. I understand that a reasonable attempt to contact me will be made.

I understand that part of the camp healthcare supervisor's role at camp is to dispense medication and that this will not occur unless she/he has written authorization and instructions from the child's doctor to dispense non-prescription and/or prescription medication (including vitamins, nutritional supplements, etc.). **All medications must be in their original pharmacy containers, with an intact current prescription label. *No exceptions will be made*.**

Please send all medications, including Epi Pens and inhalers, with your child on the first day of camp.

I also give permission for my child to receive the following non-prescription medications that I have checked below if the nurse deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Child's weight: _____ lbs. □ Antacid □ Advil □ Benadryl □ Tylenol
□ Cough drop □ Topical creams/lotions

HIPAA Privacy Rule: *I authorize the use of information to promote and monitor well-being while in camp, and as necessary, provision of first aid/emergency care as best as possible, according and not limited to certifications, training, and availability.*

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed camp activities except as noted. I understand that willful omission of information that prevents GSNNJ staff from providing adequate care of my child may potentially result in dismissal of my child from camp.

Read This Statement Before Signing:

I give permission for my child to participate in all camp activities including visits to nearby parks and bus trips outside of the program site. I consent that my child may be photographed, videotaped, and/or recorded, and the electronic images/recordings may be made public and used for promotion of Girl Scouting free of any claims. I agree not to send my daughter to the program if she is not in physical and emotional condition to take part in program activities. I agree not to send my daughter to the program if she is not participating in the field trip that day. Girls are not permitted to have in their possession or use while attending the program: alcohol, tobacco, illegal drugs, animals/pets, or weapons. Cell phone use is not permitted during the program. I understand that the program manager reserves the right to send home, without refund, any child who is unable to adjust, is repeatedly defiant, or in the case of an illness, accident or health hazard, where it is in the best interest of the children and/or program. We acknowledge that the child will make the Girl Scout Promise and accept the Girl Scout Law. The child has our permission to join Girl Scouts, if not already a member.

Signature of parent/guardian:_____ Date: _____

Completed Health History Forms are due by May 30, 2019 or immediately upon registration if registering after that date. Submit the completed form via fax to 973-248-8050, scan/email to Gigi Mauder at gmauder@gsnnj.org, or by mail to Girl Scouts of Northern New Jersey, attn: Celebrate Girls Summer Program, 95 Newark Pompton Turnpike, Riverdale, NJ 07457.