girl scouts of northern new jersey

Summer Day Camp Health History Form 2021

Camp Attending: ☐ Jockey Hollow ☐ Lake Rickabear

THIS HEALTH HISTORY FORM MUST BE COMPLETED NO LATER THAN JUNE 1, 2021.
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.

Girl Name: _____ **Date of Birth:** _____ **Age:** _____
Address: _____ **Grade in Sept. 2021:** _____
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.

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: _____
REQUIRED:
☐ I have attached a copy of my child's current immunization record.
☐ My child is not immunized; I have attached the GSNNJ waiver (Email healthforms@gsnnj.org for waiver).

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: _____
Food Allergies: _____
_____
Penicillin: _____
Other Drugs: _____

Poison Ivy: _____
Hay Fever: _____
Other Allergies: _____
Prescribed Epipen? ☐ No ☐ Yes
Can Self Administer Epipen? ☐ No ☐ Yes

Medication taken routinely (prescription and OTC): _____

Camper Name: _____ 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 health 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.

Signature of parent/guardian:_____ Date: _____

Submit the completed form via scan/email to healthforms@gsnnj.org, fax to 973-927-7683, or by mail to Girl Scouts of Northern New Jersey, attn: Summer Camp, 1579 Sussex Turnpike, Randolph, NJ 07869.

If emailing, please scan and save using a PDF format. Photos will not be accepted. Please use a smartphone scan app in lieu of taking a photo of the Health History Form. Please retain a copy for your records.