girl scouts of oregon & sw washington

Day Camp Health History & OTC Medications

Adult ❑ Camper ❑

Name _____ Date of Birth _____ Sex _____ Age _____

Address _____ City _____ State _____ ZIP _____

Parent/Guardian Name(s) _____

Primary Phone (_____) _____ Secondary Phone (_____) _____

Family Medical/Hospital Insurance Carrier _____ Policy or Group # _____

Emergency Contact #1: Name _____ Relationship _____

Daytime Phone (_____) _____ Evening Phone (_____) _____

Emergency Contact #2: Name _____ Relationship _____

Daytime Phone (_____) _____ Evening Phone (_____) _____

Health History Record (Check all that apply)

Chronic or recurring illnesses:

❑ Heart Defect / Disease _____
❑ Seizures _____
❑ Bleeding / Clotting _____
❑ Asthma _____
❑ Diabetes _____
❑ Other (specify) _____

Any restrictions concerning physical activities?

❑ No ❑ Yes. Please describe any conditions:

_____

_____

Allergies:

❑ Food,Nuts _____
❑ Insect Stings _____
❑ Medicine / Drugs _____
❑ Other (specify) _____

Special dietary restrictions? _____

Tetanus ❑ Date of last booster? (year) _____

Please list any medications taken on a daily basis, including over-the-counter medications: _____

_____

Any other relevant health concerns _____

_____

Camper Only - Over-the-Counter Medications

According to our *Day Camp Protocols and Health Care Procedures*, our health care staff can administer certain types of over-the-counter (OTC) medications. In order for your camper to be able to receive these, we need to have a parent/guardian signature.

Check box if camper MAY RECEIVE any of the following OTC medications:

❑ Acetaminophen (Tylenol or generic)
❑ Ibuprofen (Advil or generic)
❑ Diphenhydramine (Benedryl or generic)
❑ Non-medicated cough drops
❑ Insect repellent (may contain up to 15% DEET)
❑ OTC Antacid (Tums)
❑ Calamine lotion
❑ Antibiotic Ointment
❑ Sunscreen (without PABA, minimum SPF 30)
❑ Hydrocortisone

Weight of child for dosage purposes: _____

(Unchecked boxes means camper MAY NOT receive that medication.)

Camper

I/we verify that this health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me. In case of illness or injury, I/we give permission for her/him to receive first aid and to receive emergency treatment from a licensed physician, emergency medical services or other health care professional. It is understood that all reasonable efforts will be made to contact the parent or guardian. I/we verify my child has my permission to receive the above-mentioned over-the-counter medications.

Signature of Parent(s)/Guardian _____ Date _____

Adult

I verify that this health history is complete and accurate. I am able to engage in all prescribed activities, except as noted.

Signature of Adult _____ Date _____