

# HEALTH HISTORY AND EXAMINATION FORM FOR CHILDREN AND ADULTS

Girl Scouts – Diamonds of Arkansas, Oklahoma and Texas  
615 West 29<sup>th</sup> St, North Little Rock, AR 72114

UNIT \_\_\_\_\_  
SESSION \_\_\_\_\_  
CAMP \_\_\_\_\_  
NAME \_\_\_\_\_  
*For staff use only:*

<b>Full Name</b>	<b>Birth Date</b>	<b>Age</b>
<b>Home Address</b> (street) (city) (state) (zip)	<b>Social Security #</b>	
<b>Parent/Guardian</b>	<b>Home Phone</b>	
<b>Home Address</b> (if different than above)	<b>Cell Phone or Pager</b>	
<b>Business Address</b>	<b>Business Phone</b>	

**2<sup>nd</sup> Emergency Contact if parent not available:**  
 \_\_\_\_\_ at \_\_\_\_\_  
 (Name & Relationship) (Phone number with area code)

**3<sup>rd</sup> Emergency Contact if 2<sup>nd</sup> contact not available:**  
 \_\_\_\_\_ at \_\_\_\_\_  
 (Name & Relationship) (Phone number with area code)

**Doctor** \_\_\_\_\_ at \_\_\_\_\_  
 (Name) (Phone number with area code)

Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Name of Policyholder \_\_\_\_\_ Policy/Group Number \_\_\_\_\_

**Attach Copy of Health Insurance Card**

**Permission to Provide Necessary Treatment or Emergency Care:**  
 I hereby give permission to the medical personnel selected by the camp director/event leader to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director/event leader to secure and administer treatment, including hospitalization, for the person named above. I understand that my family health insurance will provide primary coverage for such medical treatment and services, and that the insurer of the Girl Scouts - Diamonds of Arkansas, Oklahoma and Texas provides secondary coverage. This completed form may be photocopied for trips off of Girl Scout property.

Signature of parent/guardian or adult participant/staff \_\_\_\_\_ Date \_\_\_\_\_

**Permission to Participate:**  
 I give permission for my daughter/ward \_\_\_\_\_ to: (1) participate in the program activities at \_\_\_\_\_ (2) appear in photos, which become property of Girl Scouts - Diamonds of Arkansas, Oklahoma and Texas and may be used for publicity purposes. I understand and agree to cooperate with all regulations. I will not allow her to attend if she is not in good physical condition. I also hereby assume the risk for any injuries that are sustained in the pursuit of these activities at resident camp or in the business of providing program activities off Girl Scout property and do hereby release, and forever discharge the Girl Scouts - Diamonds of Arkansas, Oklahoma and Texas, and its employed and volunteer staff from any actions, suits, damages, claims, or judgments that may result from any personal injury sustained while on the premise of a Girl Scout resident camp or in the pursuit of Girl Scout related activities.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH HISTORY:** The following information is required and must be completed by the parent/guardian or adult participant/staff. Any changes should be reported to camp health personnel upon participant's arrival at camp. Provide complete information so that the camp staff will be aware of your needs.

**Section I: Illnesses and injuries (check those that apply and explain below)**

**Chronic or Recurring illness**

Ear infections                       Bleeding/Clotting Disorders                       Hypertension                       Asthma  
 Heart Defect/Disease                       Muscular/Skeletal Disorders                       Seizures                       Diabetes  
 Other (specify & explain) \_\_\_\_\_

Any Hospitalizations, Operations, serious injuries in the last year? \_\_\_\_\_  
\_\_\_\_\_

Other diseases/disabilities? \_\_\_\_\_  
\_\_\_\_\_

Is participant currently under the care of physician or psychologist? \_\_\_\_\_

**Section II: Allergies (Check those that apply and specify nature of allergic reaction in open space below)**

Animals     Hay Fever     Pollen     Food     Plants     Insect stings     Medicine/drugs  
 Other (Specify) \_\_\_\_\_ Is participant currently taking any allergy medication? \_\_\_\_\_

**\*\*\*Explain any checks. Also, please specify type of reaction and symptoms noted, and any particular treatment in case of exposure to allergy or allergic reaction:**

**Section III: Other Health Conditions (Check those that apply explain in open space below)**

Bed wetting                       Emotional disturbances                       Constipation                       Fainting  
 Menstrual cramps                       Motion sickness                       Hearing impairment                       Nosebleeds  
 Sleep disturbances                       Dietary restrictions                       Glasses/contact lenses                       Anemia  
 Current mental or psychological condition requiring medication, treatment, or special restrictions or considerations while at camp.  
 Other (Specify) \_\_\_\_\_

**\*\*\*Explain any checks:**

**Section IV --OVER THE COUNTER MEDICATIONS:** It is often convenient for participants if certified health personnel have parental permission to administer over-the-counter medications such as Bactine (for minor scrapes), Tylenol (for headache or menstrual cramps), Calamine Lotion &/or Benadryl (for insect bites or poison ivy), etc.

I give my permission for my daughter/ward to be given over-the-counter medications (such as those listed above) to relieve minor or temporary discomfort. I understand that if my daughter is given over-the-counter medication, it will be administered according to the manufacturer's instructions and according to any information/directions listed on this health record.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Please indicate usual dosage: \_\_\_\_\_  
\_\_\_\_\_

OR, if you do not wish for your daughter to receive any over-the-counter medications, sign here: \_\_\_\_\_

**\*\*\*\*\*Section V: Immunization History – Attach a copy of current Immunization History to this form.**  
This information is required.

**Section VI --HEALTH EXAMINATION**

Participant's Name \_\_\_\_\_ Date of examination \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

**To be completed by Physician:**

I have examined the above-named participant.

In my opinion, the applicant:

- is ABLE to participate in an active camp program.
- is NOT able to participate in an active camp program.

The participant is under the care of a physician for the following conditions: \_\_\_\_\_

Current treatment at the time of this report includes: \_\_\_\_\_

Any other physician comments or recommendations: \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

Printed name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Section VII –Describe any Dietary or Activity related RESTRICTIONS**

Dietary restrictions (describe): \_\_\_\_\_

Activity restrictions/limitations (describe): \_\_\_\_\_

**Please provide any additional information about the participant's behavior and physical, emotional, or mental health about which the adult in charge and/or health supervisor should be aware.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all event activities except as noted.

Signed \_\_\_\_\_ Date \_\_\_\_\_

