girl scouts of eastern iowa and western illinois

Camp and Travel Health Form

Camp and Travel Health History and Examination Form

PLEASE SELECT ONE:
- ☐ Girl
- ☐ Adult
- ☐ Staff

PLEASE NOTE

A complete, signed Health Card is required for ***all*** participants (girl and adult).
The physical examination including physician's signature is required for any trip of more than 5 nights or trips outside the Iowa/Illinois region.

Name (Last, First, Initial)	Name & Relationship of parent/guardian completing this form			Daytime Phone ( )		
Address (Number and Street)	City or Town	State	Zip Code	Date of Birth	Age	Grade entering

EMERGENCY CONTACT INFORMATION: Must include parent/guardian or person completing form.

NAME	RELATIONSHIP	DAYTIME PHONE	EVENING PHONE	CELL PHONE

Are there any legal custodian issues we should be aware of? ☐ **No** ☐ **Yes** **If yes, please explain:** _____

INSURANCE INFORMATION - Is the participant covered by family medical/hospital insurance? ☐ **Yes** ☐ **No**

If yes, carrier or plan name _____ Carrier phone number _____

Policy Number _____ Group Number_____

Name of insured _____ Relationship to participant _____

Family Doctor: _____ Phone Number: _____

Dentist/Orthodontist:_____ Phone Number: _____ _____

Date of last health examination _____ Were there any medical problems at the time? _____

HEALTH HISTORY – Must be completed by parent/guardian.
Check all that apply and explain any of the checked items, restrictions or other conditions we should be aware of.

CHRONIC OR RECURRING ILLNESS

- ☐ Asthma
- ☐ Bleeding /Clotting Disorders
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Mononucleosis
- ☐ Musculoskeletal Disorders
- ☐ Seizures/Epilepsy
- ☐ Sinusitis
- ☐ Tuberculosis
- ☐ Other (specify) _____

OTHER HEALTH CONDITIONS

- ☐ ADD/ADHD
- ☐ Bedwetting
- ☐ Behavioral Disturbances
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Emotional Disturbances
- ☐ Fainting
- ☐ Frequent Colds
- ☐ Frequent Headaches
- ☐ Frequent Sore Throats
- ☐ Other (specify) _____

- ☐ Frequent Stomach Aches
- ☐ Hearing Impairment
- ☐ Menstrual cramps
- ☐ Motion Sickness
- ☐ Night Terrors
- ☐ Nosebleeds
- ☐ Pediculosis (Lice)
- ☐ Sleepwalking
- ☐ Wears glasses/contacts
- ☐ Wears orthodontic devices
- ☐ Other (specify)_____

Explanation(s)

In the last year, has the participant had:
- ☐ An injury/illness requiring medical attention
- ☐ A surgical operation or fracture
- ☐ Restrictions from participating in P.E. class
- ☐ An illness lasting longer than 5 days
- ☐ Hospital treatment
- ☐ Exposure to a contagious disease

Is the participant currently:
- ☐ Receiving psychological counseling
- ☐ Under a physician's care
- ☐ Restricted from physical activity
- ☐ Taking prescription medication *(Complete reverse side.)*
- ☐ Taking over-the-counter medication *(Complete reverse side.)*

Please explain any items checked above. Give dates and include any information that would be helpful to trip advisors in relation to these health conditions. Add an additional sheet if needed.

ALLERGIES: ☐ No known allergies
This participant is allergic to: ☐ Food ☐ Medicine ☐ the environment (insect stings, hay fever, etc) ☐ other
(Please describe below what the participant is allergic to and the reaction seen.) Do you carry an EpiPen? ___

Diet, Nutrition - Please let us know of any special nutritional accommodations or dietary needs.
- ☐ Eats a regular diet
- ☐ Eats a regular vegetarian diet
- ☐ Has special dietary needs. (Please describe below.)

Has participant had:
Chicken Pox ☐ **Yes** ☐ **No**
Measles/German Measles ☐ **Yes** ☐ **No**
Mumps ☐ **Yes** ☐ **No**
Hepatitis ☐ **Yes** ☐ **No**

Participants' first and last name _____

OTHER INFORMATION

Has your daughter been taught about menstruation? ☐ **Yes** ☐ **No**

Has your daughter begun menstruation? ☐ **Yes** ☐ **No**

List necessary adaptations or limitations: _____

_____

Height:_____ Weight:_____

General physical and emotional status:

The following medications are available during travel. These products are recommended by our consulting physicians through standing orders. They will be administered under the health advisor's or designee's supervision; dosage as appropriate for weight and/or age.
Please check which medications can be given to your girl.

- ☐ Acetaminophen (Tylenol)
- ☐ Decongestant (Sudafed)
- ☐ Antacid (Tums)
- ☐ Diphenhydramine (Benadryl)
- ☐ Ibuprofen (Motrin)
- ☐ Antihistamine (Claritin)
- ☐ Antidiarrheal (Pepto-Bismol)
- ☐ Expectorant (cough suppressant, cough drops)

RECORD OF IMMUNIZATION

Please list date of last immunization or provide a copy of immunizations or write "All Current." Adult campers need only to list the last date of Tetanus.

Name of immunization	Date of last immunization
MMR (Measles, Mumps, Rubella)	
Polio	
Hib B	
Hepatitis B	
Varicella (Chicken Pox)	
Tetanus (adults)	
DTaP/Tdap (Diphtheria, Tetanus, Pertussis)	
Tuberculin Test year last given	Result

What have we forgotten to ask about your child?

Prescription or over-the-counter medications brought from home MUST be in their original container, clearly labeled, and can only be given according to package directions or as prescribed by a physician. ***(Please complete the list below for all regularly administered medications)***

MEDICATION	CONDITION TREATED	DOSAGE	TIME OF DAY	TAKEN WITH FOOD?
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other _____	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other _____	
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ As needed ☐ Other _____	

Please read the following statement and sign on the line at the bottom, indicating your agreement.

This health history is complete and accurate so far as I know and the above stated person has my permission to participate in travel and all associated activities, including strenuous activities such as hiking, swimming, climbing hills, horseback riding (if applicable). I understand that when participating in Girl Scout activities, participants may be photographed for print, video or electronic imaging and that those images may be used in published formats and belong to the Girl Scouts.

I hereby give permission for my girl to receive routine health care, prescribed and non prescription medication, arrange necessary transportation, seek emergency medical treatment, including X-rays, routine tests, injections and/or anesthesia and/or surgery, for the participant named above. In case of an emergency, the trip advisor will call at least one of the contacts on the list. If none of the contacts on this form can be contacted, I consent to treatment for my daughter under the supervision of and as deemed advisable by a physician licensed under the Medicine Practice Act.

I understand the information on this form will be shared on a "need to know" basis with council staff and trip advisors in order to provide adequate safety and health care to the participant. The completed forms may be photocopied. I entrust care of my child to the trip advisors. Beyond this I will not hold the trip advisors or Girl Scouts of Eastern Iowa and Western Illinois responsible or liable.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PHYSICAL EXAMINATION

NOTE TO PHYSICIAN: In order to travel outside the region or on an extended trip the above participant is required to have a physical examination. The participant or their parent/guardian has chosen to share information about the last exam done within 12 months prior to the trip departure date Please review the completed health history and complete the information pertinent to the participant's physical health and her/his ability to participate and sign and date below.

I have examined the travel participant named above.
In my opinion, her/his health;

- ☐ **does** allow his/her participation on this trip
- ☐ **does not** allow her/his participation on this trip

Recommendations and Restrictions during travel:

Date of Physical Examination: _____

Additional Health Information trip advisors should be aware of:

Licensed physician's name:

_____

Licensed physician's signature:

_____

Street Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Date _____