



Girl Scouts of Kentuckiana  
RESIDENT CAMP HEALTH HISTORY AND RELEASE

Camper Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_ Evening Phone: (\_\_\_\_\_) \_\_\_\_\_

*Please list emergency contacts other than the parent/guardian.*

Emergency Contact #1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact #2: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**HEALTH HISTORY (Check all that apply.)**

**Diseases**

- Chicken Pox
- Measles
- German Measles
- Mumps

**Allergies**

- Animals
- Food
- Hay Fever
- Insect Stings
- Medicine/Drugs
- Plants
- Pollen
- Other (specify): \_\_\_\_\_

**Chronic or Recurring Illness**

- Ear Infections
- Heart Defect/Disease
- Seizures
- Bleeding Disorder
- Asthma
- Hypertension
- Diabetes
- Musculoskeletal Disorders
- Other (specify): \_\_\_\_\_

**Other Health Conditions**

- Frequent Colds
- Stomach Upsets
- Constipation/Diarrhea
- Menstrual Cramps
- Motion Sickness
- Wears Glasses
- Wears Contact Lenses
- Bed Wetting
- Sleep Walking
- Frequent Headaches
- Kidney Trouble
- Hearing Impairment
- Frequent Sore Throats
- Frequent Ear Infections
- Pediculosis (lice)
- Nosebleeds
- Night Terrors
- Fainting
- Other (specify): \_\_\_\_\_

Please explain the care and treatment of any items checked above, including allergy reaction and management of the reaction. Indicate any information useful to camp staff in relation to these health conditions.

Describe any current health conditions or complicating medical problems requiring medication, any medications she will be taking while at camp, treatment, special restrictions while at camp, or in the event of an emergency.

This health history is correct and my daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician. In case of illness or injury to my daughter, I hereby authorize and give consent to the camp staff to obtain and provide medical treatment and services as are deemed necessary.

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

## CAMPER PROFILE

Parent/Guardian, please attach separate sheet if more space is needed.

My camper's overall health is:  Good  Fair  Poor

Please give us any information that can help your camper's counselors work best with your camper (please be specific): \_\_\_\_\_  
\_\_\_\_\_

Are there any activities you would like to encourage or restrict for your camper?

Encourage: \_\_\_\_\_

Restrict: \_\_\_\_\_

Are there any special dietary needs (please be specific regarding foods, amounts, reactions, religious guidelines) or is she a vegetarian? \_\_\_\_\_  
\_\_\_\_\_

Does your camper eat:  Much  Little  Moderately  Often

Does your camper have any special needs or do you have any behavioral management suggestions (ADD, ADHD, other) to help us assist your camper? \_\_\_\_\_  
\_\_\_\_\_

Has your camper started menstruation?  Yes  No

If not, is she prepared for it?  Yes  No

My camper has these sleep habits (circle all that apply):

Light Sleeper    Heavy Sleeper    Sleepwalking    Bedwetting    Nightmares

How does your camper feel about coming to camp; what is she looking forward to?  
\_\_\_\_\_  
\_\_\_\_\_

Has your camper previously attended:  Day Camp  Resident Camp

Has your camper been away from home?  1 night  2 nights  3 or more nights

What do you want your camper to learn/experience at camp? \_\_\_\_\_  
\_\_\_\_\_

Does your camper have any fears? \_\_\_\_\_  
\_\_\_\_\_

Have there been any recent changes in your camper's life or at home that may be affecting her (e.g. a recent divorce, death, new sibling, etc.)? \_\_\_\_\_  
\_\_\_\_\_

Are there any specific behaviors you've been working on at home (thumb sucking, bedwetting, temper tantrums, name calling, arguing, etc.)? \_\_\_\_\_  
\_\_\_\_\_

What are your concerns about her stay at camp? \_\_\_\_\_  
\_\_\_\_\_

## HEALTH EXAMINATION

This side to be filled in by physician after review of health history with parent/guardian.

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

Date of last physical exam (include year): \_\_\_\_\_

**s-satisfactory    x-not satisfactory (explain)**

_____ Posture and Spine	_____ Teeth	_____ Skin
_____ Heart	_____ Feet	_____ Lungs
_____ Eyes	_____ Ears	_____ Nose
_____ Throat	_____ Abdomen	_____ Menstruation

## IMMUNIZATION HISTORY

Please give the date of last immunization for:

DPT _____	Diphtheria _____	TD _____	Tetanus _____
_____	Pertussis _____	_____	Diphtheria _____
_____	Tetanus _____	_____	_____

_____ Oral Polio	_____ Measles	_____ Mumps
_____ HIB	_____ HBPV	_____ Tuberculin Test
_____ Other (specify): _____	_____	Result: _____

In my opinion, the applicant is able to participate in an active camp program.

Yes  No (if necessary, please attach additional pages for more information)

The applicant is under the care of a physician for the following conditions:

Current treatment at the time of this report includes:

Physicians comments/recommendations, including details of any treatment to be continued at camp, any allergies, diet restrictions, etc.

The allergy and medication information supplied by the parent/guardian is accurate, and/or I have supplied additional information to the best of my knowledge.

Licensed Physician's Name: \_\_\_\_\_

Licensed Physician's Signature: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_