

Complete and send in this form by June 1
 Send to: Girl Scouts, Attn: Camp Registrar, 10715 Hickman Rd,
 Des Moines, IA 50322 or fax: (515) 278-5988

Camp Assignment: Joy Hollow Camp Sacajawea Camp Tanglefoot

Session Name _____ Date _____ Code _____

A health examination form is required in order to attend camp.

This part to be filled in by adult and reviewed with physician at the time of examination

Name (Last, First, Initial)				Sex	Birth
Address				City or Town	State
Zip				Phone	()
In Emergency Notify		Address		Relationship	Phone
					()

INSURANCE INFORMATION: please complete the following:

Carrier	ID Number	Group Number
Member Services Phone Number	Address	
()		

HEALTH HISTORY: (check if you have had any of the following)

<p>DISEASES</p> <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney	<p>ALLERGIES</p> <input type="checkbox"/> Animals _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Hay Fever _____ <input type="checkbox"/> Insect Bites/Stings _____ <input type="checkbox"/> Medicine/Drugs _____ <input type="checkbox"/> Pollen _____ <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other	<p>My Daughter has permission to take or use the following:</p> <input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Advil/Ibuprofen <input type="checkbox"/> Sudafed/decongestant <input type="checkbox"/> Benadryl/antihistamine <input type="checkbox"/> Tums/antacid <input type="checkbox"/> Robitussin/expectorant <input type="checkbox"/> Calamine lotion <input type="checkbox"/> Cough drops
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Please describe conditions and give dates:

Operations or serious injuries: _____
 Hospitalizations: _____
 Has the camper been told about menstruation? YES NO Has she started menstruation? YES NO
 Other Diseases/disabilities: _____

Comments where applicable:

Fainting _____ Bedwetting _____ Constipation _____ Emotional Disturbances _____ Specific activities to be encouraged _____ Special medical or dietary regimen to be followed (specify) _____	Sleeping Disturbances _____ Menstrual Cramps _____ Nosebleeds _____ Other _____ Restricted _____
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PLEASE LIST ANY CURRENT MEDICATIONS BEING TAKEN – INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

HEALTH INFORMATION PRIVACY STATEMENT

The **Girl Health Examination Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff volunteers in order to provide adequate participant safety and health care. This health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of majority of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant, or their legal representative. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I authorize emergency medical treatment be given if needed for illness or injury. **This health history is complete and accurate. I give permission to engage in all prescribed activities, except as noted.**

SIGNATURE: _____ DATE: _____
 (PARENT/GUARDIAN)

**Health Forms are considered part of the permanent camp record and cannot be returned.
 Please keep a copy.**

