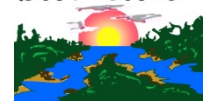


Two Rivers Day Camp - Health History Form

TWO RIVERS
DAY CAMP



Please print clearly in ink – ALL FIELDS ARE REQUIRED – one form needed per person

Camper Youth Staff Adult Sibling

First Name: _____ MI: _____ Last Name: _____ Troop #: _____

Custodial Care (complete if under 18) Both Parents Mother only Father only Other (please list) _____

Name of Physician/Clinic:		Phone: ()	
Medical/Hospital Insurance Company:		<input type="checkbox"/> ✓ if none	
◆ Photocopy of front & back of Health Insurance Card must accompany this form ◆		Policy or Group #:	
Dental Insurance Company:		<input type="checkbox"/> ✓ if none	
Policy or Group #:			
DOB:	Immunizations up to date? Yes / No	Please list dates of all immunizations or include a copy of immunization records	
Tetanus: MM/DD/YY	Diphtheria: MM/DD/YY	Polio: MM/DD/YY	MMR: MM/DD/YY
HepB: MM/DD/YY	Chicken Pox (Varicella): MM/DD/YY		
Date of Last Health Exam:	Were there any medical problems at the time? Yes <input type="radio"/> No <input type="radio"/>		
	If yes, please explain:		
Does participant have any physical, mental or psychological conditions requiring medication, treatment or other special restrictions or considerations? Yes <input type="radio"/> No <input type="radio"/>	If yes, please explain:		
Does participant take any prescribed medications or over-the-counter drugs on a regular basis? Yes <input type="radio"/> No <input type="radio"/> Note – If taking ANY medications at camp, they must be in original container & be accompanied by a medication form.	If yes, please state medication and reason:		
Is participant restricted or limited from participating in any physical activity? Yes <input type="radio"/> No <input type="radio"/>	If yes, please explain:		
Please provide a record of past medical treatment, if any, including injuries or surgeries:			
Participant has the following health conditions/allergies: <input type="checkbox"/> None	<input type="checkbox"/> ADHD <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Other _____ ALLERGIES:		
Does participant have any dietary restrictions or food allergies? Yes <input type="radio"/> No <input type="radio"/>	If yes, please explain:		

If needed, the Day Camp First Aider may give the following medications/treatments:

Tylenol/Acetaminophen	<input type="radio"/> Yes	<input type="radio"/> No	Note: (Please list weight for children under 12) _____
Motrin/Ibuprofen	<input type="radio"/> Yes	<input type="radio"/> No	Note: (Please list weight for children under 12) _____
Midol/generic	<input type="radio"/> Yes	<input type="radio"/> No	Note: _____
Orajel/generic (for numbing bites & stings)	<input type="radio"/> Yes	<input type="radio"/> No	Note: _____
Saline (eye wash or wound cleaning)	<input type="radio"/> Yes	<input type="radio"/> No	Note: _____
Antibiotic cream (for cuts)	<input type="radio"/> Yes	<input type="radio"/> No	Note: _____
Bug spray	<input type="radio"/> Yes	<input type="radio"/> No	Note: _____
Sunscreen	<input type="radio"/> Yes	<input type="radio"/> No	Note: _____
Calamine Lotion/generic	<input type="radio"/> Yes	<input type="radio"/> No	Note: _____
Benadryl/generic	<input type="radio"/> Yes	<input type="radio"/> No	Note: _____

Participant's Name: _____

MEDICATION INFORMATION – FOR ALL MEDICATIONS THAT WILL BE BROUGHT TO CAMP

MEDICATION AND DOSE: _____

REASON FOR MEDICATION: _____

PLEASE CHECK AS TO WHEN MEDICATION SHOULD BE GIVEN

TO BE GIVEN AS NEEDED _____ PRESCRIBED TIMES ONLY _____

	MON	TUES	WED	THURS	FRI	SAT
BREAKFAST	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	
LUNCH						NOT AT CAMP
DINNER	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP
BEDTIME	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP

MEDICATION AND DOSE: _____

REASON FOR MEDICATION: _____

PLEASE CHECK AS TO WHEN MEDICATION SHOULD BE GIVEN

TO BE GIVEN AS NEEDED _____ PRESCRIBED TIMES ONLY _____

	MON	TUES	WED	THURS	FRI	SAT
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LUNCH						NOT AT CAMP
DINNER	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP
BEDTIME	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP

MEDICATION AND DOSE: _____

REASON FOR MEDICATION: _____

PLEASE CHECK AS TO WHEN MEDICATION SHOULD BE GIVEN

TO BE GIVEN AS NEEDED _____ PRESCRIBED TIMES ONLY _____

	MON	TUES	WED	THURS	FRI	SAT
BREAKFAST	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	
LUNCH						NOT AT CAMP
DINNER	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP
BEDTIME	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP	NOT AT CAMP		NOT AT CAMP

Parent/Guardian Authorization

This health form is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my child should not participate in the prescribed activities except as noted. In the event that my child needs medical attention while participating in Girl Scout activities, I authorize the adult in charge to see that my child receives routine healthcare, medications, reasonable first aid and to transport my child to a health care facility for emergency services as needed.

Signature of parent/guardian: _____ Date: _____

Adult Authorization

This health form is complete and accurate. I am able to engage in all prescribed activities except as noted.

Signature of adult: _____ Date: _____

Make sure to include a copy (front & back) of health insurance card with Health Form