girl scouts of southwest texas

Camp La Jita RESIDENT CAMP HEALTH HISTORY FORM

Bring a copy of the form with you and turn in at nurse's station during check in.

Name _____ Birthdate _____ Age at Camp___
Last First Middle

Home Address _____
Street Address City State Zip Code

Parent/ _____
Guardian *Name Address if different from camper Home Phone Work Phone Cell Phone*

Parent/_____
Guardian *Name Address if different from camper Home Phone Work Phone Cell Phone*

Emergency Contact Other than Parent/Guardian:

Name	***Relationship***	***Home Phone***	***Work Phone***	***Cell Phone***
Name	***Relationship***	***Home Phone***	***Work Phone***	***Cell Phone***

Health History (Check all that apply):

Diseases
[ ] Chicken Pox
[ ] Measles
[ ] German Measles
[ ] Mumps
[ ] Other _____

Allergies - Describe specific allergy and reaction:
[ ] Animals _____
[ ] Food _____
[ ] Insect Stings_____
[ ] Medicine/Drug _____
[ ] Plants _____
[ ] Pollen _____
[ ] Milk _____

Chronic or Recurring Illness - Please give explanation:
[ ]Ear Infections _____
[ ] Sinus _____
[ ] Heart Defect/Disease _____
[ ] Seizures _____
[ ] Bleeding Disorders _____
[ ] Asthma _____
[ ] Diabetes _____
[ ] Musculoskeletal Disorders _____
[ ] Cancer _____

I _____ hereby give Camp La Jita permission to administer the following over the counter medications if health supervisor deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Symptom/Illness
Headache
Upset Stomach
Diarrhea
Menstrual Cramps
Poison Ivy
cuts or skin infections
Insect Bites/Stings
Athletes Foot
Swimmers Ear

OTC Medication
[ ] Tylenol B Children's Motrin
[ ] Pepto Bismol
[ ] Imodium AD
[ ] Ibuprofen or Midol
[ ] Calamine Lotion
[ ] Triple Antibiotic Ointment
[ ] Calamine and/or Diphenhydramine (Benadryl)
[ ] Anti-Fungal Treatment
[ ] Alcohol/Vinegar Drop (all campers receive at pool)

Current Medications being taken:

[ ] This person takes no medication on a routine basis.

[ ] This person takes medication as follows: Minor
Med #1 _____
Dosage _____
Reason _____
Med #2 _____
Dosage _____
Reason _____

Please describe conditions and give dates:
Operations or Serious Injury:
_____
_____

Hospitalizations:
_____
_____

Other diseases/disabilities:

_____

_____

Specific activities to be encouraged:

_____

_____

Specific activities to be discouraged:

_____

_____

Special dietary regime to be followed:

_____

_____

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. I hereby give permission to the physician selected by the Camp Director to order x-rays, routine tests and treatment for the health of my child, and in the event I can not be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as needed above.

Signature of Parent/Guardian_____ **Date** _____

PHYSICAL EXAM PORTION: Must be filled out by Physician after review of health history with parent/guardian.

Date of Exam: _____

Height _____ Weight _____ Blood Pressure _____

Appearance B Nutrition _____

Eyes: Without Glasses: **R20**_____ **L20**_____ With Glasses**: R20**_____ **L20**_____

Ears: _____ Hearing: **R**_____ **L** _____

Code: Satisfactory (S) Not Satisfactory (NS)

Nose _____ Throat _____ Heart _____ Lungs_____ Abdomen_____ Skin_____ Musculoskeletal_____

General Physical Status _____ General Emotional Status _____

General Notes:

_____

__

_____

Physician Comments and Recommendations: Give details or indicate management of significant illness.

_____

_____

Record of Immunizations:

	Date		Date
D T P	_____	Haemophilus influenza B	_____
PCV	_____	Hepatitis B	_____
TD	_____	MMR	_____
IPV	_____	Varicella (Chicken Pox)	_____
Tetanus	_____		

This person is in satisfactory condition and may engage in all usual activities except as noted. **Licensed Physician's Information**:

_____ _____ _____

Printed Name Signature Date

Address _____

City State Zip

Phone Number (_____)_____