

**DAY CAMP - MAIL TO BEDFORD OFFICE BY JUNE 1, 2010
RESIDENT CAMP – BRING TO CAMP ON FIRST DAY OF SESSION**

Photocopy health card for your records and if your daughter will attend more than one camp/trip.

Medical Examination, Immunization and Health History – 2010

THIS FORM CANNOT BE RETURNED TO YOU.

This side to be completed by parent/guardian

NAME OF CAMP/TRIP _____

SESSION # _____

NAME (LAST, FIRST, MIDDLE)		AGE	DATE OF BIRTH		HEIGHT	WEIGHT
HOME ADDRESS		CITY	STATE	ZIP	HOME PHONE () ()	
PARENT/GUARDIAN	(H) PHONE () ()	(W) PHONE () ()		CELL/PAGER () ()		
PARENT/GUARDIAN	(H) PHONE () ()	(W) PHONE () ()		CELL/PAGER () ()		
EMERGENCY CONTACT	(H) PHONE () ()	(W) PHONE () ()		CELL/PAGER () ()		
IS THERE AN ADULT WHO SHOULD NOT HAVE CONTACT WITH YOUR CHILD?						
FAMILY MEDICAL INSURANCE COMPANY			POLICY #		NAME OF INSURED PARENT	

HEALTH HISTORY (Check those that apply)

- | | |
|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Disease/Defect |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Musculoskeletal Disorders |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Behavioral Challenges | <input type="checkbox"/> Other (Specify below) |

ALLERGIES

LIST

Food	
Drug	
Insect Stings	
Plant Pollen	
Animals	
Hay Fever	
Other	

MEDICATIONS USED & PURPOSE

Only prescription medication may be brought to camp. These must be in the original container, labeled with child's name, physician's name and dosage.

Please explain any of the above _____

Indicate and explain below past medical treatment for the following: operation/serious injuries _____; chronic or recurring illness _____; dietary restrictions _____; learning difficulties _____; physical, social, or emotional special needs _____.

Immunization Record

Minimum immunization requirements: 3 doses of DTP and/or Td vaccine; 3 doses of polio; 2 doses of live measles vaccine; 1 doses of live mumps vaccine; and 1 doses of live rubella vaccine. Additional doses of MMR required prior to 7th grade. Td booster required every 10 years. Initial Hepatitis B required if born on or after 1/1/1993.

VACCINE TYPE	DATE OF LAST BOOSTER	DATE PRIMARY SERIES COMPLETED
DTP or Td (Diphtheria, Tetanus, Pertussis or Tetanus, Diphtheria)		
POLIO		
MEASLES (red or hard measles)		
RUBELLA (3-day or German measles)		
MUMPS		
HEPATITIS B		

For Camp Use Only
SCREENING RECORD

Recent Exposure _____ No _____ Yes, explain below
Any special needs _____ No _____ Yes, explain below
Signs/Symptoms of illness/injury _____ No _____ Yes, explain
Medications given to health center _____ No _____ Yes, listed
Updates to health history _____ No _____ Yes, marked

Screener _____

Permission to Treat: I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to treat minor injuries or illness as directed by a licensed physician; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer proper treatment, including hospitalization, anesthesia or surgery, for the person named above, and to release medical information to the camp director or her designee for purposes of treatment. **I agree to be financially responsible for any treatment provided in accordance with this permission. I agree to indemnify the Girl Scouts of Green and White Mountains (GSGWM) for any medical expenses incurred pursuant to this authorization and to hold GSGWM harmless with respect to medical care administered to my child while in their custody.** This completed form may be photocopied for trips out of camp.

Signature of parent or legal guardian

Date

Mental, Emotional, and Psychological Health

- 1. This camper has an emotional health concern that will impact camp participation.....[] Yes [] No
2. This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder.....[] Yes [] No
3. This camper has a significant life event that continues to affect the camper's life/health.....[] Yes [] No
4. This camper uses an individualized learning plan at school.....[] Yes [] No
5. This camper requires an aide at school.....[] Yes [] No

If "yes" was the answer to any of the five statements above, please attach a statement from your child's professional (e.g. physician, psychiatrist, therapist) that addresses the following with regard to your child's participation at camp:

- A. Describes the concern and the camper's management plan (including medications) while at camp;
B. Describes the behaviors that will indicate to our staff that your camper needs professional referral; and
C. Provides a recommendation from this professional supporting your child's participation in our camp program.

Activity Permission and Release

I give permission for this camper to participate in all activities described for the program in which she is registered, the activities checked below and all other activities deemed appropriate by the camp unless noted below.

- [] Swimming [] Boating [] Fire building [] Outdoor cooking [] Off-site Field trips [] Horseback riding
[] Climbing tower [] Archery [] Diversity discussions [] Camp chores

If you would like additional information about any of these activities prior to giving permission, please contact the Girl Scout Council, 888-474-9686.

In addition, this camper may not participate in the following activities: _____

Activity limitations or special conditions to be watched (bedwetting, fainting, sleep disturbances, menstrual cramps, etc.) _____

I have requested Girl Scouts of the Green and White Mountains to allow this camper to participate in activities described for the program which she is registered, the activities checked above and all other activities deemed appropriate by the camp unless noted above. As a condition of receiving this benefit I, the undersigned, do hereby agree to the following:

I understand that this camper's participation in this activity can expose this camper to dangers both from known and unanticipated risks. Acknowledging that such risks exist, I hereby release and discharge Girl Scouts of the Green and White Mountains, its officers, agents and employees from any and all claims or liability for personal injury or property damage this camper may suffer while participating in the activity; including, but not limited to, any claim arising out of any condition of the premises at which the activity is held or the conduct of any person in connection with the preparation for, supervision of, or conduct of any activity, whether planned or unplanned. I specifically agree to release and hereby release Girl Scouts of the Green and White Mountains and the officers, agents, and employees of the camp for any negligence of the camp, or its officers, agents or employees.

Signature of parent or legal guardian

Date

Permission to Administer Over-the-Counter Medications

I hereby give permission for Girl Scouts of the Green and White Mountains to administer the over-the-counter medications for the following conditions and others if the nurse or designated staff member deems it necessary. Dosages will be administered according to directions on the bottle or as a physician directs in our camp standing orders. The following conditions may be treated: Headache, Upset Stomach, Diarrhea, Indigestion, Fever, Menstrual Cramps, Poison Ivy, Insect Bites.

Signature of parent or legal guardian

Date

Permission to Participate in Girl Scout Program

I am willing to have my daughter be a Girl Scout member. You may use my photograph for publicity including, but not limited to, internet and videotapes. I will not hold GSGWM responsible for loss of personal articles brought to camp. I have read the council policies, registration information and financial obligations and agree to abide by them.

Signature of parent or legal guardian

Date

Medical Examination (To be completed by licensed physician, state approved nurse practitioner or physician's assistant) is required within two years of the last day of your session.

Table with 2 columns: NAME OF PERSON, DATE EXAMINED. Rows include: ESSENTIAL FINDING THAT ARE DEVIATIONS FROM NORMAL, LIMITATIONS, RESTRICTIONS, OR TREATMENT TO BE CONTINUED AT CAMP, In my opinion, this person's condition allows participation in an active camp program., SIGNATURE OF PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN'S ASSISTANT, PRINT NAME AND ADDRESS OF ABOVE, PHONE ()

NOTE: If this form is incomplete for medical, personal conviction or religious reasons, please contact Girl Scouts of the Green and White Mountains for a waiver refusing permission to treat.