



# Camp Jessie Bloom 2019

## Health History & Health Examination Form

Full payment & Health Forms due Friday, June 7<sup>th</sup>

**PLEASE PRINT CLEARLY**

Girl's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

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

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

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor or Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Plan: \_\_\_\_\_ Group No.: \_\_\_\_\_

If Military: Sponsor's Name: \_\_\_\_\_

Sponsor's Soc. Sec.: \_\_\_\_\_ Rank: \_\_\_\_\_ Unit: \_\_\_\_\_

**Allergies:**

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

**Other Health Conditions:** (Give approximate dates)

- |                       |                       |
|-----------------------|-----------------------|
| _____ Chicken Pox     | _____ Deformities     |
| _____ Measles         | _____ Limb Brace      |
| _____ German Measles  | _____ Special Shoes   |
| _____ Mumps           | _____ Dental Braces   |
| _____ Asthma          | _____ Glasses         |
| _____ Hepatitis       | _____ Hearing Aid     |
| _____ Rheumatic Fever | _____ Ear Infections  |
| _____ Diabetes        | _____ Convulsions     |
| _____ Epilepsy        | _____ Other (Specify) |
| _____ Fainting        |                       |

Additional details our staff should know about: \_\_\_\_\_

\_\_\_\_\_

**Immunizations:** (Give dates)

- |                       |                       |
|-----------------------|-----------------------|
| _____ DPT             | _____ Measles/Rubella |
| _____ Tetanus Booster | _____ TB Tine         |
| _____ Oral Polio      | _____ Other           |

Is there any restriction on physical activity? Explain: \_\_\_\_\_

\_\_\_\_\_

List below all medications your camper **will** be taking to camp, including aspirin and cough drops:

<b>What</b>	<b>Why</b>	<b>Instructions</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any non-prescription medications you **DO NOT** want your daughter to be administered at camp:

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**Parent Authorization:**

This health history is correct to the best of my knowledge, and the camper herein described is free of any potential health problems that might restrict participation at camp (except as noted by me and/or the physician) and is free of any communicable diseases that might endanger other campers.

In the event I cannot be reached in an emergency, I hereby give permission for emergency care to be given. This authorization applies whether the charges are covered by Girl Scout insurance or by myself. I give this authorization with knowledge that Girl Scout health insurance is secondary and does not provide coverage for every incident.

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**Parent/Guardian's Signature**

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**Date**

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**Medical Examination**

**Must be filled out and signed by a doctor, RN, PA or NP**

Camper's Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temperature: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Examination findings – please check if condition is satisfactory. If not, please explain.

- Eyes & Vision \_\_\_\_\_
- Skin \_\_\_\_\_
- Throat \_\_\_\_\_
- Ears & Hearing \_\_\_\_\_
- Heart \_\_\_\_\_
- Lungs \_\_\_\_\_
- Legs \_\_\_\_\_
- Abdomen \_\_\_\_\_

I find this camper in good physical condition for competitive sports and outdoor physical activities.

This camper's activities should be limited for the following reasons:

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Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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