girl scouts of ohio's heartland

PLEASE PRINT IN BLUE/BLACK INK

Adult DAY CAMP HEALTH HISTORY FORM

Name of Adult _____ Name of Day Camp _____

Address _____

Emergency Contact's Name _____ Primary Phone ( ) _____

HEALTH HISTORY

Health History *(Please explain any specific needs or limitations)* _____

_____

Past medical treatment *(if any)* _____

Allergies and dietary restrictions *(Specify allergic reaction and management)* _____

_____

Medications to be taken at camp *(Prescribed or OTC - please include inhalers and Epi-pens)* _____

_____

Are all immunizations up to date? Yes ( ) No ( ) *Please explain below.* Date of last tetanus _____

_____

Description of any current physical, or mental challenges requiring medication, treatment, or special restrictions or considerations while at camp. *Being aware of these needs helps us to provide a safe and enjoyable experience for each individual.* _____

_____

Please provide any information that may be useful in relation to any of these health conditions. Also, indicate activities to be encouraged or restricted by physician, any special dietary needs, or reasons to medications listed above. _____

_____

Are you covered by family medical/hospital insurance: Yes ( ) No ( ) *If no, please explain below.*

_____

Authorization to permit medical treatment. By signing below, I hereby give permission to the Girl Scouts of Ohio's Heartland Council, Inc. (Girl Scouts), their employees, members, or volunteers to provide routine first aid and to supervise self-medication and seek medical assistance on behalf of myself in the event I am injured or ill, and I am unable to indicate my wishes regarding treatment. I understand that the Girl Scouts and its members, volunteers, or employees shall not be held responsible for the cost of treatment, and in fact are authorized to bind me as the financially responsible party for my medical treatment. I hereby grant permission to physicians and other licensed health care providers and their designees to administer medical care through injury or illness evaluation first aid care, and referral to duly licensed medical personnel when indicated. I authorize the release of all information totreatment providers, and will hold the Girl Scouts in no way responsible for the release of this information to any party.

Signature _____ Date _____

Please print name _____