

Camp Assignment: Trefoil Ranch Camp Cloud Rim Other _____

Program Title _____ Session Date _____

PLEASE BRING THIS FORM WITH YOU TO HIGH ADVENTURE EVENTS, TRIPS, TROOP CAMPING OR MINICAMPS.
 PLEASE RETURN THIS FORM BY MAY 13 IF YOU ARE ATTENDING A WEEK-LONG SUMMER CAMP AT
 CAMP CLOUD RIM OR TREFOIL RANCH.



HEALTH HISTORY FORM

Name (Last, First, Initial)		Parent or Guardian (if minor)			Phone	
					()	
Address	City or Town	State	Zip	Birth	Age	Sex
In Emergency Notify		Address		Relationship	Phone	
					()	

INSURANCE INFORMATION: (Please complete the following)

Carrier	ID Number	Group Number
Member Services Phone Number	Address	
()		

HEALTH HISTORY: (check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions From Parent: (if minor)
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney	<input type="checkbox"/> Animals _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Hay Fever _____ <input type="checkbox"/> Insect Stings _____ <input type="checkbox"/> Medicine/Drugs _____ <input type="checkbox"/> Plants _____ <input type="checkbox"/> Pollen _____ <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other _____	My daughter has permission to take or use the following: {} Tylenol/Acetaminophen {} Advil/Ibuprofen {} Sudafed/decongestant {} Benadryl/antihistamine {} Tums/antacid {} Robitussin/expectorant {} Calamine lotion {} Cough drops

Please describe conditions and give dates:

Operations or serious injuries: _____

Hospitalizations: _____

Other diseases/disabilities: _____

Comments where applicable:

Fainting _____ Sleeping disturbances _____

Bed wetting _____ Menstrual cramps _____

Constipation _____ Nosebleeds _____

Emotional disturbances _____ Other _____

Specific activities to be encouraged _____ Restricted _____

Special medical or dietary regimen to be followed (specify) _____

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN ON SEPARATE PAPER AND ATTACH – INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

HEALTH INFORMATION PRIVACY STATEMENT

The **Health History Form** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff volunteers in order to provide adequate participant safety and health care. The health form will be retained by Girl Scouts of Utah or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant, or their legal representative. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I authorize emergency medical treatment be given if needed for illness or injury.

This health history is complete and accurate. I give permission to engage in all prescribed activities, except as noted.

Signature of self or Parent/Guardian (for minors) _____ DATE: _____