



Resident Camp Forms

Programs that are 3 nights or longer.






Thank you for registering your Girl Scout for a resident camp program. This document contains all the forms you will need to complete and return prior to your Girl Scout attending camp. If you have questions about these forms, please contact Cheryle Hatch, Camp and Program Registrar, at (801)716-5145 or at chatch@gsutah.org.

Please mail the completed forms by May 18*to:

Girl Scouts of Utah
Attention: Program and Camp Registrar
PO Box 57280
Salt Lake City, UT 84157-0280

***If you registered your Girl Scout for a camp program after May 18**, mail completed form to above address at least two weeks prior to your camper’s session.

*** If you registered your Girl Scout for a camp program within two weeks of the program**, bring the completed forms to camp with your camper.

	PHYSICAL EXAMINATION (Physical needs to have been completed within 24 months of camp program.)
	HEALTH HISTORY AND CONSENT
	OUTDOOR PROGRAM RELEASE
	ALL ABOUT YOU
	MEDICATION LOG (Bring to camp if you’re bringing medications with you.)

Reminder: Final camp payments are due by May 18.



Physical Examination

Location of Program: Camp Cloud Rim Trefoil Ranch _____
 Program Date: _____ Program Name: _____

Physical Examination: Required for participants attending a camp/trip that is three nights or longer. Form needs to be completed by a licensed physician, nurse practitioner, physician's assistant, or registered nurse. Completed within 24 months of program the participant is attending.

Health History: Separate document. Required for participants attending resident camp, troop camping at resident camp, and extended troop trips lasting three nights or longer.

Medication Log: Separate document. To be completed if participant is bringing prescription medications to program.

If attending a resident camp program, mail this completed form by May 18th to:

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PARTICIPANT INFORMATION

Participant Name: _____ Date of Examination: _____

HEALTH EXAMINATION:

Height: _____ Weight: _____ B.P.: _____ Appearance/Nutrition: _____

Without Glasses With Glasses
 Eyes: R 20/____ L 20/____ R 20/____ L 20/____ Hearing: R ____ L ____

Code: Satisfactory (S)
 Not Satisfactory (NS)
 Not examined (NE)

Ears: _____ Nose: _____ Throat: _____ Teeth: _____

Heart: _____ Lungs: _____ Abdomen: _____ Skin: _____

Head/hair (no lice): _____ Musculoskeletal: _____

General physical and emotional status: _____

Urinalysis*: _____ HGB*: _____

* Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty.

Other notes:

RECORD OF IMMUNIZATIONS:

(You may include a copy of your Utah School Immunization Record.)

Immunization	Primary Series (Yr.)	Last Booster (Yr.)
DTP, Dtap, DT, Td <small>(D-Diphtheria, T-Tetanus, P-Pertussis, aP-acellular Pertussis)</small>	_____	_____
HiB	_____	_____
Polio (IPV or OPV)	_____	_____
MMR <small>(M-Measles, M-Mumps, R-Rubella)</small>	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hepatitis B (HBV)	_____	_____
Varicella (Chickenpox)	_____	_____
Typhoid & Paratyphoid	_____	_____
Cholera	_____	_____
Yellow Fever	_____	_____
Typhus	_____	_____
Rocky Mtn. Spotted Fever	_____	_____
Tuberculin Test: Last Date: _____	Result: _____	

PHYSICIAN'S COMMENTS AND RECOMMENDATIONS:

Give details or indicate management or significant of illnesses.

This person has a condition which may limit activity for this event? Yes No

Does this person have any chronic disease? Yes No

If overweight, will condition restrict activity? Yes No

Does this person have any condition which might limit her/his participation in swimming, hiking, living at high altitude or other strenuous activities? Yes No

PHYSICIAN'S INFORMATION AND AUTHORIZATION TO PARTICIPATE

This person is in satisfactory condition and may engage in all usual activities except as noted.

Licensed physician's name: _____

Licensed physician's signature: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Date: _____

HEALTH FORMS ARE CONSIDERED A PART OF THE PERMANENT CAMP RECORD AND WILL NOT BE RETURNED.



Health History & Consent Form

Location of Program: Camp Cloud Rim Trefoil Ranch _____
Program Date: _____ **Program Name:** _____

Health History: Required for participants attending resident camp, troop camping at resident camp, and extended troop trips lasting three nights or longer.

Physical Examination: Separate document. Required for participants attending a camp/trip that is three nights or longer. Form needs to be completed by a licensed physician, nurse practitioner, physician's assistant, or registered nurse. Completed within 24 months of program the participant is attending. **PLEASE KEEP A COPY FOR YOUR RECORDS.**

Medication Log: Separate document. To be completed if participant is bringing prescription medications to program.

If attending a resident camp program, mail this completed form by May 18 to:
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PARTICIPANT INFORMATION

Participant Name: _____ Home Phone: _____ Age: _____ Birth Date: ____/____/____
 Mailing Address: _____ City: _____ State: _____ Zip Code: _____
 If a minor: Parent/Guardian #1's Name: _____ Parent/Guardian #2's Name: _____
 Parent/Guardian #1's Phone: _____ Parent/Guardian #2's Phone: _____

EMERGENCY CONTACT INFORMATION (If participant is a minor, please list a non-parent/guardian contact)

Person to be notified: _____ Relationship to camper: _____
 Phone #1: _____ Phone #2: _____

INSURANCE INFORMATION

Insurance Company: _____ Members Services Phone: _____
 Address: _____ Name of Insured: _____ ID Number: _____

HEALTH INFORMATION

Check "Yes" or "No" for each statement. Explain "Yes" answers below and explain any accommodations needed.

- | | | |
|--|---|---|
| 1. Asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Sleeping disorder/sleep walking? <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Visual disability? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Heart defect/disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Deaf/hard of hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Seizures/epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Bleeding/clotting disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. Behavioral problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Frequent ear infections? <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Frequent sore throats? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Recent infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Has this person menstruated? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Sinusitis? <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Chronic/reoccurring illness? <input type="checkbox"/> Yes <input type="checkbox"/> No | a. If not, has she been told about it? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Bronchitis? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Skin conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No | b. If so, is her menstrual history normal? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Fainting/dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. ADD/ADHD? <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Operations/serious injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Stomach upsets? <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Autism Spectrum Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Other diseases/conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Constipation/diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Emotional disability? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 11. Bed wetting? <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Learning disability? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 12. Urinary tract infections? <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Explanation of "Yes" answers: _____

DIETARY RESTRICTIONS

Please specify any accommodations needed.
 Vegetarian Vegan Gluten-free Lactose-free Other

ALLERGIES

Please explain severity of allergies (contact, ingestion, smell, etc.)
 Drug Food Plants/Pollen/Insects Other

OVER-THE-COUNTER MEDICATIONS

If participant is a minor – My child has permission to take or use the following as needed:

- Tylenol/Acetaminophen
- Advil/Ibuprofen
- Sudafed/decongestant
- Benadryl/antihistamine
- Tums/antacid
- Robitussin/expectorant
- Calamine lotion
- Cough drops

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 (if minor): _____
 Date: _____

HEALTH FORMS ARE CONSIDERED A PART OF THE PERMANENT CAMP RECORD AND WILL NOT BE RETURNED.



Outdoor Program Release Form

Location of Program: <input type="checkbox"/> Camp Cloud Rim <input type="checkbox"/> Trefoil Ranch Program Date: _____ Program Name: _____

Required for participants attending resident camp and troop camping at resident camp.

Please mail the completed form by May 18 to:

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Name: _____

PHOTO/PUBLIC RELATIONS RELEASE Yes No

I give my permission for photographs, video, audiotape, and artist renditions to be taken of me/my camper while involved in camp programs. I allow Girl Scouts of Utah to release said images for the promotion and publicity of Girl Scouting.

HIGH RISK ACTIVITIES

I recognize that some camp activities such as horseback riding, climbing, rappelling, biking, rafting, ropes course, archery, and the waterfront are high-risk activities and can be dangerous. I will be responsible for ensuring that me/my camper brings the required equipment and I/she will only participate if I/she is in good physical condition.

ADVENTURE AND LEADERSHIP PROGRAMS

I understand that I/my camper may participate in hikes and adventure activities off of camp property. Overnight stays are also part of these camp sessions. Campers in leadership programs may be transported between Camp Cloud Rim and Trefoil Ranch during their session. I authorize camp staff to transport me/my camper to and from these activities.

Signature of self or parent/guardian (for minors)

Date

FOR GIRLS ONLY:

DESIGNATED DRIVER RELEASE

To insure the safety of your camper, she will only be released to those listed below. I give my permission for my camper to be:

Brought to camp by:

Name

Relationship

And taken home by:

Name

Relationship

Signature of parent/guardian

Date



All About You

Location of Program: <input type="checkbox"/> Camp Cloud Rim <input type="checkbox"/> Trefoil Ranch
Program Date: _____ Program Name: _____

This form is to be completed by the parent/guardian of the camper. All information will be kept confidential. Please mail the completed form by May 18 to:

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Camper's name _____ Camp nickname _____ Age _____

1. What are some of your Girl Scout's hobbies or interests?
2. What is something your Girl Scout is really good at or excels in?
3. What is your Girl Scout worried about?
4. Has your Girl Scout been to camp or away from home before? If so, explain.
5. What do you hope for your Girl Scout's camp experience?
6. Do you have any suggestions for helping your Girl Scout succeed if she should get homesick or have trouble getting along with others? (Campers don't have access to phones.)
7. Do you have any special concerns for your daughter?
8. Additional comments (use back of page if needed).

