








School Year Camp Programs (Minicamps) Forms

Minicamp programs from mid-August thru mid-June where girls come to camp by themselves, with their troop, or with an adult family member.

Thank you for registering you and/or your Girl Scout for a camp program. This document contains all the forms you will need to complete **prior to arriving at camp**. Please bring these forms with you to camp. If you have questions about these forms, please contact us at 801-265-8472 or registrations@gsutah.org.

	<p>PROGRAM RELEASE</p> <ul style="list-style-type: none"> • If <u>girls are attending programs with an adult family member present</u>, both adults and girls will need to fill out this form.
	<p>HEALTH HISTORY</p> <ul style="list-style-type: none"> • If <u>girls</u> are attending the camp program <u>without an adult family member present</u>, you will need to fill out this form.
	<p>PHYSICAL EXAM FORM</p> <ul style="list-style-type: none"> • All girls and adults will need to have a healthcare provider fill out this form if they are <u>attending a program lasting more than 3 days, 2 nights</u>. • Physical Exams need to have been completed within 24 months of program date. <ul style="list-style-type: none"> ○ For the <u>2017</u> camp season, we will be moving to a 12 month rotation for summer camp.
	<p>MEDICATION LOG (girls and adults; only needed if bringing medications to camp)</p> <ul style="list-style-type: none"> • All medications (prescriptions, over-the-counter, herbal, etc.) will only be accepted if they are in their original containers. • All prescription medications must be prescribed for the person receiving them. • Please put all medication containers in a Ziploc bag with the person's name written on the Ziploc. • You will fill out the Medication Log and bring it to camp along with your medications.
	<p>EPI PEN AUTHORIZATION AND MEDICATION FORMS</p> <ul style="list-style-type: none"> • Only fill out if you will be bringing an EPI pen to camp with you. • These forms must be signed by a health care provider.



PROGRAM RELEASE FORM

Families need to only fill out one form.

Bring this completed form to the program you will be attending. This form will not be returned.

The camp/program director has the right to refuse to admit anyone who does not meet the acceptable health conditions (temperature, contagious disease, etc.).

PROGRAM NAME _____

PROGRAM DATE _____

PARTICIPANT #1 INFORMATION

Participant Name: _____ Troop #: _____ Birth Date: ____/____/____ Age: _____

Allergies: Yes No – If Yes, please list: _____

Special medical or other pertinent information:
 Yes No – If Yes, please list: _____

Limitations of activity:
 Yes No – If Yes, please list: _____

PARTICIPANT #2 INFORMATION

Participant Name: _____ Troop #: _____ Birth Date: ____/____/____ Age: _____

Allergies: Yes No – If Yes, please list: _____

Special medical or other pertinent information:
 Yes No – If Yes, please list: _____

Limitations of activity:
 Yes No – If Yes, please list: _____

PARTICIPANT #3 INFORMATION

Participant Name: _____ Troop #: _____ Birth Date: ____/____/____ Age: _____

Allergies: Yes No – If Yes, please list: _____

Special medical or other pertinent information:
 Yes No – If Yes, please list: _____

Limitations of activity:
 Yes No – If Yes, please list: _____

PARENT/GUARDIAN INFORMATION OF PARTICIPANTS WHO ARE MINORS

Parent/Guardian #1

Name: _____

Relationship to Participant: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Cell Phone: _____

Alternative Phone: _____

Parent/Guardian #2

Name: _____

Relationship to Participant: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Cell Phone: _____

Alternative Phone: _____

EMERGENCY CONTACT INFORMATION (If minors are attending, please list a non-parent/guardian contacts)

Contact #1

Name: _____

Relationship to Participant: _____

Cell Phone: _____

Alternative Phone: _____

Contact #2

Name: _____

Relationship to Participant: _____

Cell Phone: _____

Alternative Phone: _____

DESIGNATED DRIVER RELEASE

To ensure the safety of minors, girls will only be released to those listed below.

- Be taken to program by: Name _____ Relationship to minor _____ Phone _____
- Be taken home by: Name _____ Relationship to minor _____ Phone _____

PERMISSION STATEMENT

I give permission for all participants listed above to:

- Attend the Girl Scout program listed above.
- Be treated by a health care provider, first aider, health supervisor, and/or hospital in case of an emergency.
- Have photographs, video, audiotape, and artist renditions to be taken of them while involved in Girl Scout 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 Girl Scout 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 I/my Girl Scout(s) 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 Girl Scout owned property. Overnight campouts are part of some programs. Girl Scouts in leadership programs may be transported to various program sites during their programs. Girl Scouts in high adventure programs may also be transported to program sites. I authorize Girl Scout staff/volunteers to transport me/my Girl Scout to and from these activities.

PLEASE SIGN

Signature of Self or Parent/Guardian of Minors

Date



Health History & Consent Form

Program Date: _____	Program Name: _____
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PARTICIPANT INFORMATION (HW20.1A-D)

Participant Name: _____ Birth Date: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Preferred Phone Number: _____ Second Preferred Phone Number: _____

If a minor: **Parent/Guardian #1** Name: _____ **Parent/Guardian #2** Name: _____

Address: _____ Address: _____

Cell Phone: _____ Cell Phone: _____

Alternative Phone: _____ Alternative Phone: _____

EMERGENCY CONTACT INFORMATION (If participant is a minor, please list a non-parent/guardian contact) (HW20.1E)

Contact #1 Name: _____	Contact #2 Name: _____
Relationship to Participant: _____	Relationship to Participant: _____
Cell Phone: _____	Cell Phone: _____
Alternative Phone: _____	Alternative Phone: _____

PHYSICIAN OR HEALTH CARE FACILITY (HW20.1F)

Name of Physician or Health Care Facility: _____ Phone Number: _____

INSURANCE INFORMATION

Insurance Company: _____ Members Services Phone: _____

Address: _____ Name of Insured: _____ ID Number: _____

HEALTH INFORMATION (HW5.1B and HW5.1F)

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

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

Explanation of "Yes" answers (use another sheet of paper if needed): _____

RECORD OF IMMUNIZATIONS FOR GIRL MEMBERS (HW5.1D)

For travel outside of the United States, please email programs@gsutah.org for assistance with additional required vaccinations.

Kindergarten thru 6th Grade

- DTaP/DT HiB Polio (IPV/OPV)
- MMR Hep B Hep A
- Chicken Pox (Varicella)

7th Grade thru 12th Grade

- K thru 6th Grade immunizations
- Tdap Booster
- Meningococcal

Last Tetanus Immunization

____ (month) ____ (year)
[REQUIRED]



Please check one of the following:

- The participant **IS** up-to-date on all immunizations listed above as required by the Utah Health Department and GSUSA.
- The participant **IS NOT** up-to-date on all immunizations listed above as required by the Utah Health Department and GSUSA.
If a participant is any missing immunizations listed above, she cannot attend Girl Scout programs lasting 3 nights or more.
- The participant claims exemption to immunizations for medical, religious, or personal reasons (additional form is required from Utah Health Department).

PLEASE SIGN _____	_____
Signature of Parent/Guardian	Date

Participant Name: _____

DIETARY RESTRICTIONS (HW5.1C)

- Vegetarian Vegan Gluten-free Lactose-free Other

Please specify any accommodations needed:

ALLERGIES (HW5.1C)

- Drug Food Plants/Pollen/Insects Other

Please explain severity of allergies (contact, ingestion, smell, etc.):

PROGRAM PARTICIPATION (HW5.1A)

I understand the activities that are involved with the program that myself/camper is attending. If clarification is needed, please contact the program contact person or the Girl Scouts of Utah (801-265-8472 or registrations@gsutah.org). Below is a list of activities that, due to health concerns, myself/camper will be exempt from:

OVER-THE-COUNTER MEDICATIONS (HW5.1E)

Health services will provide over-the-counter medications listed below.

If participant is a minor, please mark that your child has permission to take or use the following as needed:

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

MEDICATIONS BROUGHT TO CAMP (HW5.1E)

All medications brought to Girl Scout programs, including prescription, over-the-counter, herbal, and so forth, must be turned in with the Medication Log form during check-in.

All medications must be in the original containers. All prescription medications must be prescribed for the individual taking the medication.

PERMISSION TO TREAT (HW9.1A)

- I give permission for the staff/volunteers to provide, seek, and consent to routine health care, administration of prescribed medications, administration of over-the-counter medications agreed to on this form, and emergency treatment of said participant.
- I authorize staff/volunteers to transport said participant to off-property health care facilities if deemed necessary by staff.
- For minors, in the event the parent/guardian cannot be reached during an emergency, I give permission for staff/volunteers to contact the emergency contacts listed on this form. In the event no one can be reached, I give permission for emergency medical providers to secure and administer treatment including, but not limited to x-rays, routine tests and treatment, and/or hospitalization.

PLEASE SIGN →

 Signature of Parent/Guardian

 Date

Refusal to sign this section requires you to contact the Girl Scouts of Utah for a refusal-to-treat form prior to the program date (801-265-8472 or registrations@gsutah.org). (HW9.1B)

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

PLEASE SIGN →

 Signature of Parent/Guardian

 Date

DESIGNATED DRIVER RELEASE

To ensure the safety of minors, girls will only be released to those listed below.

- Be taken to program by: Name _____ Relationship to minor _____ Phone _____
- Be taken home by: Name _____ Relationship to minor _____ Phone _____

PERMISSION STATEMENT

I give permission for all participants listed above to:

- Attend the Girl Scout program listed above.
- Have photographs, video, audiotape, and artist renditions to be taken of them while involved in Girl Scout 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 Girl Scout 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 I/my Girl Scout(s) 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 Girl Scout owned property. Overnight campouts are part of some programs. Girl Scouts in leadership programs may be transported to various program sites during their programs. Girl Scouts in high adventure programs may also be transported to program sites. I authorize Girl Scout staff/volunteers to transport me/my Girl Scout to and from these activities.

PLEASE SIGN →

 Signature of Self or Parent/Guardian of Minors

 Date

RESIDENT CAMP 2016: PHYSICAL EXAMS NEED TO BE UPLOADED TO YOUR CAMPDOG.COM PROFILE BY MAY 25. PHYSICAL EXAMS NEED TO HAVE BEEN COMPLETED WITHIN 24 MONTHS OF PROGRAM DATE.

**FOR THE 2017 CAMP SEASON, WE WILL BE MOVING TO A 12 MONTH ROTATION FOR SUMMER CAMP.*

QUESTIONS: CONTACT CAMP@GSUTAH.ORG



Physical Exam Form (HW6.1)

Program Date: _____	Program Name: _____
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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, or physician's assistant. **PLEASE KEEP A COPY FOR YOUR RECORDS.**

PARTICIPANT INFORMATION

Participant Name: _____ Date of Examination: _____

HEALTH EXAMINATION:

Height: _____ Eyes (without glasses/contacts): R 20/____ L 20/____
 Weight: _____ Eyes (with glasses/contacts): R 20/____ L 20/____

Blood Pressure: _____

Abdomen	Satisfactory	Not Satisfactory	Not Examined
Appearance/Nutrition	Satisfactory	Not Satisfactory	Not Examined
Ears	Satisfactory	Not Satisfactory	Not Examined
General Physical & Emotional Status	Satisfactory	Not Satisfactory	Not Examined
Hair	No Lice	Lice	Not Examined
Hearth	Satisfactory	Not Satisfactory	Not Examined
Lungs	Satisfactory	Not Satisfactory	Not Examined
Musculoskeletal	Satisfactory	Not Satisfactory	Not Examined
Nose	Satisfactory	Not Satisfactory	Not Examined
Skin	Satisfactory	Not Satisfactory	Not Examined
Teeth	Satisfactory	Not Satisfactory	Not Examined
Throat	Satisfactory	Not Satisfactory	Not Examined

HGB*	Satisfactory	Not Satisfactory	Not Examined
Urinalysis*	Satisfactory	Not Satisfactory	Not Examined
<i>* Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty</i>			

SPECIAL DIETARY NEEDS:

	Circle One		EPI-PEN		Specific Information About Dietary Need	Physician's Initials
	Allergy	Intolerance	Yes	No		
Gluten-Free						
Lactose-Free						
Nuts						
Other						

*** Please note that the camp will help accommodate food allergies. We recommend families bring their own food in order to help supplement medical dietary needs. Contact the Camp Director for more information (camp@gsutah.org).**

PHYSICIAN'S COMMENTS AND RECOMMENDATIONS:		
Give details or indicate management or significant of illnesses.		
Does this person have asthma ?	Yes	No
If so, do they have an inhaler they'll be bringing to this event?	Yes	No
Does this person have any allergies (outside of food allergies)?	Yes	No
If so, does this person carry an EPI-pen for any of their allergies?	Yes	No
If so, what is the allergy and what are the symptoms associated with it?		
Does this person have diabetes ?	Yes	No
If so, are they able to manage their diabetes on their own?	Yes	No
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 participation in swimming, hiking, living at high altitude or other strenuous activities ?	Yes	No

PHYSICIAN'S INFORMATION AND AUTHORIZATION TO PARTICIPATE	
Form needs to be completed by a licensed physician, nurse practitioner, or physician's assistant.	
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:	_____

PARTICIPANT NAME: _____

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		<input type="checkbox"/> Breakfast								
		<input type="checkbox"/> Lunch								
		<input type="checkbox"/> Dinner								
		<input type="checkbox"/> Bedtime								
		<input type="checkbox"/> Other:								
		<input type="checkbox"/> As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		<input type="checkbox"/> Breakfast								
		<input type="checkbox"/> Lunch								
		<input type="checkbox"/> Dinner								
		<input type="checkbox"/> Bedtime								
		<input type="checkbox"/> Other:								
		<input type="checkbox"/> As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		<input type="checkbox"/> Breakfast								
		<input type="checkbox"/> Lunch								
		<input type="checkbox"/> Dinner								
		<input type="checkbox"/> Bedtime								
		<input type="checkbox"/> Other:								
		<input type="checkbox"/> As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		<input type="checkbox"/> Breakfast								
		<input type="checkbox"/> Lunch								
		<input type="checkbox"/> Dinner								
		<input type="checkbox"/> Bedtime								
		<input type="checkbox"/> Other:								
		<input type="checkbox"/> As needed								

Medication	Dosage	Time	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Comments
		<input type="checkbox"/> Breakfast								
		<input type="checkbox"/> Lunch								
		<input type="checkbox"/> Dinner								
		<input type="checkbox"/> Bedtime								
		<input type="checkbox"/> Other:								
		<input type="checkbox"/> As needed								

THIS FORM IS ONLY NEEDED IF A PARTICIPANT IS BRINGING AN EPI-PEN TO THE GIRL SCOUT PROGRAM.

IF ATTENDING A SUMMER RESIDENT CAMP PROGRAM, YOU WILL USE CAMPDOC.COM – NOT THIS FORM.

THIS FORM WILL BE USED FOR TROOP CAMPING, MINICAMPS, TRAVEL, ETC. QUESTIONS ABOUT THIS FORM? CONTACT CAMP@GSUTAH.ORG



Epinephrine Auto Injector (EAI) Authorization Form

Utah Code Ann. 26-41-101, et seq.

Name of Girl _____ Date of Birth _____

Troop # _____ (or circle JUILETE) Grade Level _____

I _____ parent/guardian (circle one) of above girl certify that the epinephrine auto injector has been prescribed for her. I authorize the administration of Epinephrine Auto Injector (EAI) medication in an emergency to the identified girl.

Parental Responsibilities: By signing below, the undersigned parent or guardian understands, acknowledges and agrees to undertake the following responsibilities and acknowledges that neither the Girl Scouts of Utah, nor any employee or volunteer for the Girl Scouts of Utah, shall be responsible for any of the following:

- The parent or guardian is to furnish the Epinephrine Auto Injector (EAI) medication and bring to the appropriate leader in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
- The parent or guardian, or other designated adult will deliver to the leader and replace the Epinephrine Auto Injector (EAI) medication within two weeks if the Epinephrine Auto Injector (EAI) single dose medication is given.
- If a Girl Scout has a change in her prescription, the parent or guardian is responsible for providing the newly prescribed information and dosing information as described above to leader. The parent or guardian will complete an updated Epinephrine Auto Injector (EAI) Authorization Form before the designated volunteer leader can administer the updated Epinephrine Auto Injector (EAI) medication prescription.
- The parent or guardian will complete, sign and deliver an Epinephrine Auto Injector (EAI) Medication form if the girl is to possess Epinephrine Auto Injector (EAI) medication at all times.

*I give permission for the leader or designee to contact my child's healthcare provider if clarification is needed to administer Epinephrine Auto Injector (EAI). I agree to meet the parental responsibilities listed above. **I give permission for the leader to release personal or medical information about my child in a health-related emergency situation if necessary.** I understand this completed and signed form authorizes personnel to administer epinephrine in emergency situations consistent with Utah Law. I further understand and acknowledge that pursuant to Utah Code Sec. 26-41-106, a leader or designee who volunteers to administer EAI Medication in an emergency in good faith shall not be liable in any civil or criminal action with respect to an anaphylactic reaction.*

Please sign

Parent Signature _____ Date _____

Parent Phone Number _____ Parent Emergency Number _____

THIS FORM IS ONLY NEEDED IF A PARTICIPANT IS BRINGING AN EPI-PEN TO THE GIRL SCOUT PROGRAM.

THIS FORM IS ONLY NEEDED IF A PARTICIPANT IS BRINGING AN EPI-PEN TO THE GIRL SCOUT PROGRAM.
IF ATTENDING A SUMMER RESIDENT CAMP PROGRAM, YOU WILL NEED YOUR HEALTH CARE PROVIDER TO SIGN THIS FORM AND THEN YOU NEED TO UPLOAD IT TO CAMPDOC.COM.
THIS FORM WILL BE USED FOR TROOP CAMPING, MINICAMPS, TRAVEL, ETC. QUESTIONS ABOUT THIS FORM? CONTACT CAMP@GSUTAH.ORG



Epinephrine Auto Injector (EAI) Medication Form

Utah Code Ann. 26-41-101, et seq.

Name of Girl _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

HEALTH CARE PROVIDER AUTHORIZATION *(must be provided)*

The above named Girl Scout is under my care. I feel it is medically appropriate for this Girl Scout to self-administer Epinephrine Auto Injector (EAI) medication, when able and appropriate, and be in possession of EAI medication and supplies at all times. The medication prescribed for this girl is:

Name of Medication _____

Dosage _____

Possible Side Effects _____

Signature Needed _____
Signature of Health Care Provider _____ **Date** _____

Parent/Guardian Authorization (mark all that apply)

- I authorize my child _____ to carry prescribed Epinephrine Auto Injector (EAI) medication and supplies.
- I authorize my daughter's leader to maintain my child's medication for use in an emergency.
- I authorize my child to self-administer and carry the prescribed medication described above.
- I do not authorize my child to carry and self-administer this medication. Please have the appropriate volunteers maintain my child's medication for use in an emergency.

My child and I understand there may be serious consequences for sharing any medications and/or supplies with other girls or volunteer staff. I further hereby release and agree to indemnify and hold harmless the Girl Scouts of Utah from any and all liabilities, claims and/or damages arising from any such sharing of medications by the above named child.

Please sign _____
Parent/Guardian Signature _____ Date _____

THIS FORM IS ONLY NEEDED IF A PARTICIPANT IS BRINGING AN EPI-PEN TO THE GIRL SCOUT PROGRAM.