

# Science Discovery Camp

## HEALTH INFORMATION FORM

(Must be completed by parent or legal guardian and signed)

The physical condition of my student, (full name and address) \_\_\_\_\_

is such that he/ she  may  may not participate in \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_

Current Weight \_\_\_\_\_

Does your child have emotional or behavioral traits of which you would like the leader to be aware? If so, please explain:

**PAST ILLNESSES:** (if applicable, give approximate dates:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Ear Infection      | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Other Allergies |
| <input type="checkbox"/> Heart Trouble      | <input type="checkbox"/> Convulsions       | <input type="checkbox"/> Drug Allergies |  |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Vision Impairment | <input type="checkbox"/> Epilepsy       |  |

Insect Sensitivity (specify):

OTHER DISEASES, ALLERGIES or details of the above:

**IMMUNIZATIONS: give month/year of LAST immunizations only:**

MMR \_\_\_\_\_ DPT \_\_\_\_\_ Polio \_\_\_\_\_ Tetanus \_\_\_\_\_

**MEDICATIONS** my student is presently taking: \_\_\_\_\_

**For treatment of:** \_\_\_\_\_

**LISTING OF THE FOLLOWING ACTIVITIES DOES NOT SIGNIFY THAT EVERY ACTIVITY WILL BE OFFERED AT EVERY EVENT/CAMP. Student has my permission to:**

SWIM <input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/>	HIKE <input type="radio"/> Yes <input type="radio"/> No	CANOE/BOAT <input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/>
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OTHER \_\_\_\_\_  Yes  No

My student's last physical exam was on: \_\_\_\_\_ The Physician is: \_\_\_\_\_

Physician's Complete Address \_\_\_\_\_ Physician's Ph # \_\_\_\_\_

If my student has had an operation or serious illness since her/his last physical examination, I will attach written permission from the licensed physician for the student to attend and participate in camp and/or troop activities.

### AUTHORIZATION FOR MEDICATION

Name of Camper \_\_\_\_\_ Complete Address \_\_\_\_\_

The following is a list of medications found in our troop first aid kit. Please check which medications may be used to treat your child if necessary. Any medications which you do not indicate as being acceptable for your child will not be used in treating your child.

- |   |  |                                       |   |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Neosporin First Aid Ointment | <input type="checkbox"/> Tylenol/Acetaminophen | <input type="checkbox"/> Pepto-Bismol | <input type="checkbox"/> Benadryl/Antihistamine |
| <input type="checkbox"/> Hydrogen Peroxide            | <input type="checkbox"/> Bug Repellant         | <input type="checkbox"/> Tums/Antacid | <input type="checkbox"/> Ibuprofen              |
| <input type="checkbox"/> Ear Drops (alcohol & water)  | <input type="checkbox"/> Sunscreen             | <input type="checkbox"/> Epsom Salts  |   |

**Substitutions will have to be provided by you.**

SPECIAL INSTRUCTIONS: Please call me before any of the above medications are used to treat my child.

**In the event of a real emergency such as injuries or illness, you will be called immediately.**

# AUTHORIZATION TO TREAT A MINOR/ADMINISTER MEDICATION

I, the undersigned parent or legal guardian of \_\_\_\_\_, a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment rendered by a licensed physician or under the general or special supervision of any member of the medical staff and emergency room staff of a duly licensed hospital in the United States and Canada. I further authorize Girl Scouts of Gateway Council or Clay County School Board representative to select a medical doctor and/or hospital of his or her choice for the purpose of diagnosis or treatment of the above named minor.

It is understood that this authorization is given in advance of any specific authority and power to render care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the above named minor, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is valid only for treatment of emergencies when the undersigned is not reasonably available to give consent.

List any restrictions:

I do  I do not authorize use of First Aid medication as indicated on the reverse of this form.

This consent shall remain effective for one (1) year from date listed below:

Time AM/PM    Month    Day, Year

\_\_\_\_\_

OR

\_\_\_\_\_  
Signed By Parent

\_\_\_\_\_  
Legal Guardian

Street Address; City State Zip \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Ext \_\_\_\_\_

Home Phone Number \_\_\_\_\_

E-Mail \_\_\_\_\_

Cell Phone Number \_\_\_\_\_