girl scouts of connecticut

Summer Camp Health Exam/History

For campers and staff

In accordance with the provisions of 105 CMR 430.000 minimum Sanitation and Safe Standards for Recreational Camps for Children, Massachusetts State Sanitary Code, Chapter IV.

Physical exams are valid for 2 years from date of last examination

☐ Camper ☐ Staff

TO BE COMPLETED BY PARENT, GUARDIAN, OR ADULT STAFF

Camper Name_____ Date of Birth _____

Address_____ Phone_____

City _____ State _____ Zip_____

Insurance Co: _____

ID# _____

Include a copy of the insurance card.

I hereby authorize the Girl Scouts of Connecticut (GSOFCT) and any medical personnel selected by the Camp to provide medical assessment and routine medical treatment and services to my child, including hospitalization, and necessary related transportation, and in case of an emergency, authorize the provision of medically necessary treatment/services, including transfer to a hospital or facility for emergency treatment/services. I release GSOFCT and its officers, directors, employees, personnel from and against any and all claims and liability arising from or related to the provision, authorization and administration of medical treatment, services and medication to my child.

Signature of Guardian_____ Phone_____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

Date of Exam

___/____/_____

____ May participate in all camp activities

____ May participate except for: _____

Does this individual have any current physical, mental or psychological condition(s) requiring medication, treatment, or special restrictions or considerations while at camp? ☐ No ☐ Yes, Explain: _____

_____

Is the individual taking prescription **and/or** over the counter medication(s)? ☐ No ☐ Yes

If yes, indicate names of medication(s): _____

Reminder! *A Medication Administration Authorization is required for* ***each*** *medication.*

Has the individual menstruated? ☐ Yes ☐ No If no, does she know about it? ☐ Yes ☐ No

Does the individual have allergies? ☐ No ☐ Yes, Explain: _____

Is this individual on a special diet? ☐ No ☐ Yes, Explain: _____

Does the individual have any other special needs? ☐ No ☐ Yes, Explain: _____

_____

This camper/staff is up to date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Date of last Tetanus_____

_____

Signature of Physician, PA, APRN or RN

Date form signed_____

Practitioner's Name_____

Address_____

City _____ State _____ Zip_____

Phone_____