girl scouts of southeastern new england

Overnight Camp Health History Form

Please complete this form and turn it in at check-in on the first day of camp. If your child requires special treatments, injections, is immune compromised, has mobility limitations (i.e. cast, crutches, or wheelchair), or any other special issues, please email the Director of Programs at caudette@gssne.org at least **two weeks prior to the start of camp**. Some scenarios will require a doctor's note.

Childs Name: _____
Home Address: _____
Date of Birth: _____Age: _____Weight: _____

Parent/Guardian 1: _____
Phone Number: _____Email: _____

Parent/Guardian 2: _____
Phone Number: _____Email: _____

Emergency Contact Name: _____
Relation To Camper: _____
Phone Number: _____Email: _____

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1. If your child has had or been exposed to a contagious disease or gets a serous cut, bruise, sprain, break, other injury, or skin rash during the two weeks prior to coming to GSSNE summer camps, please contact the Outdoor Program Manager via email.

2. All medications will be locked in the nurse's office **except Inhalers and Epi-pens/Benadryl which must be carried by participants at all times.**

3. **All medications** must be in original container and properly labeled, correlated with written instructions, and placed in a Ziploc bag labeled with camper's name.

4. **Prescription Medications:** If your child is bringing medications prescribed by a physician, the medication must be in the original container with the doctor's orders on the container. Medications will be dispensed as specified on the container unless a physician's note is attached indicating a change in dosage. The medications will be dispensed under the supervision of authorized staff members.

If your child is bringing prescription or over the counter medication, including epi-pen or inhaler, please complete the following

Medication	Dosage/Time	Reason	Is This A Prescription Medication?

Medical Background

If "YES" is circled, please give approximate dates, method of treatment, and/or restrictions. If your child is under the care of a Social Worker, psychologist, behavioral therapist, etc. please fill in specific information concerning your child's needs.

Bleeding Disorders	Yes	No	_____
Epilepsy	Yes	No	_____
Diabetes	Yes	No	_____
Asthma	Yes	No	_____
Allergy Injections	Yes	No	_____
Sleep Walking	Yes	No	_____
Fainting	Yes	No	_____
Kidney Trouble	Yes	No	_____
Heart Trouble	Yes	No	_____
Bed Wetting	Yes	No	_____
Compromised Immune System	Yes	No	_____
Emotional or Behavioral Issues	Yes	No	_____
Learning Disability	Yes	No	_____
Requires an Aide At School	Yes	No	_____
Other	Yes	No	_____
Has had a tetanus booster	Yes	No	Date: _____
Are immunizations up to date?	Yes	No	_____

Does your child have allergic reactions to any of the following:

Stings	Yes	No	Carries Emergency Medications?	Yes	No	Type: _____
Nuts	Yes	No	Carries Emergency Medications?	Yes	No	
Raw Eggs	Yes	No	Carries Emergency Medications?	Yes	No	
Eggs In All Form	Yes	No	Carries Emergency Medications?	Yes	No	
Milk Protein	Yes	No	Carries Emergency Medications?	Yes	No	
Celiac Disease	Yes	No	Carries Emergency Medications?	Yes	No	
Gluten Intolerant	Yes	No	Carries Emergency Medications?	Yes	No	
Lactose Intolerant	Yes	No	Carries Emergency Medications?	Yes	No	

Other Allergies/Dietary Restrictions:

_____

COVID-19: Does your child have COVID-19 symptoms, is waiting for test results, or has been exposed to COVID-19 in the past 48 hours? (circle one) Yes No

Can authorized staff to administer Tylenol, Benadryl, or ibuprofen if needed? (circle one)
Yes No
Can we provide insect repellent or sunscreen should your child forget theirs? (circle one)
Yes No

Permission To Secure Treatment: I give permission to have my child treated by authorized GSSNE staff or a physician in case of severe illness or emergency in which I cannot be reached. I understand that information provided on this form will be shared with those who will be directly caring for my child. If an illness or injury should arise, in which a doctor's diagnosis is required, I authorize the camps management to dismiss my child early, in which case I will assume responsibility for arranging transportation. I authorize those listed on this form to sign out my child upon presentation of photo identification. I hereby assume responsibility for all medical expenses for my child not covered by GSSNEs accidental insurance policy.

_____ _____

Parent/Guardian Signature Date