2021 Volunteer Health History Form

This form must be received by Saturday, May 1st, 2021

Mail to: Roseville Girl Scout Day Camp, P.O. Box 131881, Roseville, MN 55113-0021

Emergency Contact Information

Name: _____ **Birth date** _____ **Age at Camp** _____
Last First Middle Initial

Home Address: _____
Street Address City State Zip Code

This section must be filled out if volunteer will be 18 years of age or younger at camp –

Individual is in the custodial care of (check one): ▢Both parents ▢Mother only ▢Father only ▢Other:

Custodial Parent/Guardian Name: _____ **Daytime Phone:** _____

In an Emergency, please contact me at the following emergency phone: _____

Home Address (if different from above):

Second Parent/Guardian Name: _____ **Daytime Phone:** _____

In an Emergency, please contact me at the following emergency phone: _____

Home Address (if different from above):

FIRST EMERGENCY CONTACT	SECOND EMERGENCY CONTACT
Name:	Name:
Relationship:	Relationship:
Address:	Address:
City/State/Zip:	City/State/Zip:
Emergency Phone:	Emergency Phone:
Other than Custodial Parents, this individual **may be released** to (please list):	Are there individuals that this person **cannot be released** to? (please list):

Medical/hospital insurance: Are you covered by family medical/hospital insurance? ▢Yes ▢No

If yes, indicate insurance carrier or plan name: _____ Group#: _____

ID#: _____

Family Physician Name: _____ **Phone:** _____
Clinic Name and Address:

Family Dentist/Orthodontist Name: _____ **Phone:** _____
Clinic Name and Address:

To the best of my knowledge the Health History & Physical Exam forms are complete and accurate. I give permission for camp authorities to take necessary emergency action, which may include related transportation, admission to a hospital, x-rays, routine tests, emergency surgery, and treatment for my health. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is also my intention that a camp authority be treated as a "personal representative" for purposes of disclosing protected health information. The Girl Scout Council of River Valleys provides sickness and accident insurance to serve as secondary insurance coverage. This insurance is not intended to replace the benefits that may be available under a family/individual insurance plan. This completed form may be photocopied for trips out-of-camp. This information will be shared with camp staff as appropriate.

Volunteer signature: _____ Date: _____

Custodial parent/guardian signature: _____ Date: _____

(required if volunteer is 18 years of age or younger)

2021 VOLUNTEER HEALTH HISTORY

The following information must be filled in by you. *The intent of this information is to provide camp health care staff or emergency responders the background to provide appropriate care.* Please keep a copy of the completed form for your records. Any changes to this form should be provided to camp healthcare staff upon your arrival at camp. Please provide complete and accurate information so the camp staff can be aware of your needs.

ALLERGIES - Please list all known allergies. Describe your reaction and how to manage a reaction.

Medication allergies (please list):	**Reaction description and management of reaction:**
Food allergies (For fruits and nuts please list specifics):	**Reaction description and management of reaction:**
Other (please list): (e.g. animals, hay fever, insect stings, plant, pollen)	**Reaction description and management of reaction:**

MEDICATIONS BEING TAKEN - Please list all medications (including over-the-counter or nonprescription drugs) taken routinely.

▢ **No medications are taken on a routine basis.**

The below medications are taken as follows:

Medication #1: _____Dosage:_____ Specific times taken each day:_____

Reason for taking: _____ ▢Will be carrying on me at camp

Medication #2: _____Dosage:_____ Specific times taken each day:_____

Reason for taking: _____ ▢Will be carrying on me at camp

Medication #3: _____Dosage:_____ Specific times taken each day:_____

Reason for taking: _____ ▢Will be carrying on me at camp

Attach additional pages for more medications.

RESTRICTIONS – The following restrictions apply.

Activity restrictions List and explain any restrictions to activities (e.g. what cannot be done, what adaptations or limitations are necessary).

GENERAL HEALTH QUESTIONS – (Explain any "yes" answers below.)

Has/does the participant:	**YES**	**NO**
1. Have asthma?	▢	▢
2. Have diabetes?	▢	▢
3. Have a chronic or recurring illness/condition?	▢	▢
4. Ever had emotional or behavioral or mental difficulties that will impact their experience at camp or affect other campers/volunteers?	▢	▢
5. Had any recent injury, illness or infectious disease that will affect your experience at camp?	▢	▢

Please explain any "yes" answers, noting the number of the question.

_____

_____

_____

_____

_____

Immunizations – Please give all dates of immunization or **(✓)** ▢ **HERE IF ALL IMMUNIZATIONS ARE UP TO DATE.**

If you have NOT received any of the following immunizations, please note why:

DTP/TD(tetanus/diphtheria)_____

Polio_____

MMR_____

Use this space to provide any additional information about your behavior and physical, emotional, or mental health issues that the camp staff should be aware of.

_____

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