Child Care Health History Form

This form must be received no later than April 5th
Email rgsdaycamp@gmail.com or mail to 1776 Chatsworth Street N., Roseville, MN 55113

Emergency Contact Information

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

Home Address: _____
Street Address City State Zip Code

Child 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 If under 18 years of age, it cannot be a Parent/Guardian.	**SECOND EMERGENCY CONTACT** If under 18 years of age, it cannot be a Parent/Guardian.
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: Is the camper 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.

Custodial parent/guardian signature: _____ Date: _____

CHILD CARE HEALTH HISTORY

The following information must be filled in by the custodial parent/guardian. *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 camper's needs.

ALLERGIES - Please list all known allergies. Describe your camper's reaction and how to manage it.

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.

If medications is needed during camp, please turn in the medication for the day to the camp nurse each morning. Keep prescription medication in its original pharmacy container that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. Inhalers or epipens are to be kept in their day pack at all times.

▢ **This camper takes NO medications on a routine basis.**

The below medications are taken as follows:

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

Reason for taking: _____

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

Reason for taking: _____

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

Reason for taking: _____

Attach additional pages for more medications. Identify any medications that you may take during the school year that you will **NOT** be taking during camp. (List here):

OVER THE COUNTER MEDICATIONS - Check all items that we may give your child, if they should need medication while away from home. All medications are given based on your individual child's weight or age as listed in the instructions.

- ▢ Acetaminophen (such as Tylenol or other non-aspirin pain reliever)
- ▢ Ibuprofen (Motrin, Advil)
- ▢ Throat Lozenges
- ▢ Antihistamine (such as Benadryl)
- ▢ Calamine, Caladryl or other anti-itch lotion
- ▢ Antibiotic Ointment (such as polysporin or Neosporin)
- ▢ Hydrocortisone Cream
- ▢ Antacid (Tums)
- ▢ Saline Eye Wash
- ▢ Sunscreen (SPF 30 max)
- ▢ Bug Repellent (non-aerosol, 30% Deet max)

Child's Weight _____

RESTRICTIONS – The following restrictions apply.

Dietary

▢ Does not eat red meat ▢ Does not eat pork ▢ Does not eat eggs ▢Does not eat gluten
▢ Does not eat poultry ▢ Does not seafood ▢ Does not eat nuts ▢ Does not eat dairy products
▢ Other – specify:

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 list all dates of immunization on back of this page or **(✓)** ▢ **HERE IF ALL IMMUNIZATIONS ARE UP TO DATE.**

If your child has NOT received any of the following immunizations, please note why:

DTP/TD(tetanus/diphtheria)_____

Polio_____

MMR_____

Varicella (Chicken Pox)_____

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

_____

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Return completed form to rgsdaycamp@gmail.com or Roseville Girl Scout Day Camp, 1776 Chatsworth Street N., Roseville, MN 55113 by April 5th