

*Girl Scouts*  
*Heart of Central California*  
**CAMP STAFF HEALTH HISTORY  
AND EXAM RECORD**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
number street city state zip

Emergency Contact (Name) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Family Medical/Hospital Insurance Carrier \_\_\_\_\_ Policy/Group # \_\_\_\_\_

**HEALTH HISTORY:** (Write **Yes** or **No**)

Ear infections _____	Bleeding/clotting disorders _____	Chicken Pox _____	Poison Oak _____
Nose bleeds _____	Lyme Disease _____	Measles _____	Insect Stings _____
Heart disease _____	Hearing Aid _____	Rubella _____	Food _____
Diabetes _____	Glasses _____	Mumps _____	Drugs _____
Seizures _____	Contact Lenses _____	<b>Allergies:</b> _____	Other _____
Fainting _____	Dental braces _____	Hayfever _____	
Sleep walking _____	Orthopedic braces _____	Animals _____	Special diet _____
	Special shoes _____	Asthma _____	

Details of any **Yes** above (especially allergic reactions to bee stings or food and how do you handle it at home?)

\_\_\_\_\_

Recent operations or serious injuries \_\_\_\_\_ Date \_\_\_\_\_

Hospitalizations \_\_\_\_\_ Date \_\_\_\_\_

Any known recent illness or exposure to contagious disease (within the last six weeks)? \_\_\_\_\_ Yes \_\_\_\_\_ No Details \_\_\_\_\_

Are you currently under the care of a physician or psychologist? \_\_\_\_\_ Yes \_\_\_\_\_ No Details \_\_\_\_\_

Any activity restrictions at camp? \_\_\_\_\_

**MEDICATIONS:** List any medications being brought to camp with dosage and their purpose. Medication, both prescription and over-the-counter, **MUST** be locked in the health center.

MEDICATION	DOSAGE	PURPOSE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

