

GIRL SCOUTS OF THE CHESAPEAKE BAY

Position on Health Statements (Health Insurance Portability and Accountability Act of 1996) November 2004

Recently there have been a variety of opinions about requesting Health History and Health Statement for Girl Scout activities.

Our current position is: Troops may request health histories from families. However, it must be voluntary and no information can be shared without the parent/guardian's permission. The form is not required for most Girl Scout activities.

We have revised our health form to accommodate these criteria.

According to GSUSA Safety-Wise:

- A health history is an annual updated record of the girl's past and present health status (for example: allergies, chronic illnesses, and injuries) completed by the parent or guardian.
- A health history is required for participation in physically demanding activities such as water sports, horseback riding, skiing, and day and resident camp.
- A form may be purchased from the Council Bay Shop.

**GIRL SCOUTS OF THE CHEAPEAKE BAY
HEALTH STATEMENT**

Please print/type information – Information is voluntary and confidential

Name: _____
 Address: _____
 Parent/Guardian: _____
 Home Address: _____

Date of Birth: _____ Age: _____
 Troop #: _____
 Home Phone: () _____
 Business Phone: () _____

In case of an emergency notify:

Name: _____
 Address: _____
 Name of Family Physician: _____
 Family Medical/Hospital Insurance Carrier: _____

Relationship: _____
 Phone: () _____
 Phone: () _____
 Policy/Group Number: _____

Part I: Illness and injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness:

- | | | | |
|---|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Bleeding/Clotting disorders | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other (specify): _____ | | | |

Date of last examination: _____

Were any complicating medical problems noted in last health examination? _____

Is participant currently under the care of a physician or psychologist? _____

Since last health exam, has participant had (please mark the box if yes):

- | | |
|---|---|
| <input type="checkbox"/> a serious injury requiring medical attention? | <input type="checkbox"/> an illness lasting more than five days? |
| <input type="checkbox"/> any prescribed or over-the-counter medication? | <input type="checkbox"/> a surgical operation or fracture? |
| <input type="checkbox"/> treatment in a hospital or emergency room? | <input type="checkbox"/> any restrictions concerning physical activities? |
| <input type="checkbox"/> any exposure to contagious disease? | |

Please explain any "yes" answers to the above questions and include dates: _____

Part II: Allergies (check those that apply and specify nature of allergic reaction):

- | | |
|--|--|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Pollen | <input type="checkbox"/> Food |
| <input type="checkbox"/> Medicines/Drugs | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Plants | <input type="checkbox"/> Other: _____ |

Part III: Other health conditions (check those that apply):

- | | |
|---|---|
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Emotional disturbances |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Sickle cell trait of disease |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Special dietary regimen |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Wears glasses/contacts |
| <input type="checkbox"/> Other (please specify) _____ | |

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted. _____

<u>Immunization</u>	<u>Year Primary Series Started</u>	<u>Year of Last Booster</u>
<u>Note: State of MD Requires that DATES be listed. Current is not sufficient information.</u>		
DPT	_____	_____
Diphtheria	_____	_____
Pertussis (Whooping Cough)	_____	_____
Tetanus	_____	_____
TD	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella (German Measles)	_____	_____
Oral Polio	_____	_____
Hepatitis B	_____	_____
HIB	_____	_____
Tuberculin test result (Most recent)	_____	_____
Other: _____	_____	_____

To the best of my knowledge, the above information is current.

Signature of Parent or Guardian: _____

Date: _____

This information may be shared with medical personnel: Yes No

Signature of Parent or Guardian: _____

Date: _____

Camper Name: _____

Prescription Drug Information: All prescription drugs must be in original containers, properly labeled.

Please list any prescription drugs brought to camp.

	Brkfst	Lunch	Dinner	Bedtime	Other Dosage Instructions
Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Permission for non-prescription medication.

Please indicate below whether or not your child may be given the non-prescription medications listed below by the nurse or first aider on duty should it become necessary. All medications will be administered in dosages indicated on label.

Pain: **Yes** **No** **Call Parent First** **Notes:**

Tylenol
Ibuprofen

Upset Stomach:

Pepto Bismol
Tums

Diarrhea:

Kaopectate
Immodium AD

Allergies:

Benadryl (oral)
Benadryl (ointment)
Calamine Lotion (external lotion)

Cough:

Robitussin

Congestion:

Sudafed
Tylenol Sinus

Sunburn

Aloe Vera Gel
Solarcaine Spray

Sunscreen

Bull Frog SPF 30

Insect Repellent

Deep Woods Off (with Deet)

Parent Signature: _____

Date: _____