STEM Discovery Camp

HEALTH INFORMATION FORM

(Must be completed by parent or legal guardian and signed)

The physical condition of my student, (full name and address) _____

is such that he/she ◯ may ◯ may not participate in _____

Child's Date of Birth _____ Current Weight _____

Does your child have emotional or behavioral traits of which you would like the leader to be aware? If so, please explain:

PAST ILLNESSES: (if applicable, give approximate dates:

☐ Ear Infection ☐ Asthma ☐ Diabetes ☐ Other Allergies

☐ Heart Trouble ☐ Convulsions ☐ Drug Allergies

☐ Hearing Impairment ☐ Vision Impairment ☐ Epilepsy

Insect Sensitivity (specify):

OTHER DISEASES, ALLERGIES or details of the above:

IMMUNIZATIONS: give month/year of LAST immunizations only: MMR _____ DPT _____ Polio _____ Tetanus _____

MEDICATIONS my student is presently taking: _____

For treatment of: _____

LISTING OF THE FOLLOWING ACTIVITIES DOES NOT SIGNIFY THAT EVERY ACTIVITY WILL BE OFFERED AT EVERY EVENT/CAMP. **Student has my permission to:**

SWIM ◯ Yes ◯ No

HIKE ◯ Yes ◯ No

CANOE/BOAT ◯ Yes ◯ No

OTHER _____ ◯ Yes ◯ No

My student's last physical exam was on: _____ The Physician is: _____

Physician's Complete Address _____ Physician's Ph # _____

If my student has had an operation or serious illness since her/his last physical examination, I will attach written permission from the licensed physician for the student to attend and participate in camp and/or troop activities.

AUTHORIZATION FOR MEDICATION

Name of Camper _____ Complete Address _____

The following is a list of medications found in our troop first aid kit. Please check which medications may be used to treat your child if necessary. Any medications which you do not indicate as being acceptable for your child will not be used in treating your child.

☐ Neosporin First Aid Ointment ☐ Tylenol/Acetaminophen ☐ Pepto-Bismol ☐ Benadryl/Antihistamine

☐ Hydrogen Peroxide ☐ Bug Repellant ☐ Tums/Antacid ☐ Ibuprofen

☐ Ear Drops (alcohol & water) ☐ Sunscreen ☐ Epsom Salts

Substitutions will have to be provided by you.

SPECIAL INSTRUCTIONS: Please call me before any of the above medications are used to treat my child.

In the event of a real emergency such as injuries or illness, you will be called immediately.

AUTHORIZATION TO TREAT A MINOR/ADMINISTER MEDICATION

I, the undersigned parent or legal guardian of _____, a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment rendered by a licensed physician or under the general or special supervision of any member of the medical staff and emergency room staff of a duly licensed hospital in the United States and Canada. I further authorize Girl Scouts of Gateway Council or Clay County School Board representative to select a medical doctor and/or hospital of his or her choice for the purpose of diagnosis or treatment of the above named minor.

It is understood that this authorization is given in advance of any specific authority and power to render care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the above named minor, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is valid only for treatment of emergencies when the undersigned is not reasonably available to give consent.

List any restrictions:

◯ I do ◯ I do not authorize use of First Aid medication as indicated on the reverse of this form.

This consent shall remain effective for one (1) year from date listed below:

Time AM/PM Month Day, Year

_____

_____ **OR** _____

Signed By Parent Legal Guardian

Street Address; City State Zip _____

Work Phone Number _____ Ext _____ Home Phone Number _____

E-Mail _____ Cell Phone Number _____