

PARENT: Complete entire form and bring on first day of session.

PART I: GIRL RECORD

Girl's Name - Last, First, Middle Initial	Birth Date - MM/DD/YYYY	Age	
Home Address	City/State/Zip	Family E-Mail Address (For GSNC use only)	
Parent/Guardian Name	Day Time Telephone ()	Evening Phone ()	Cell Phone ()
Parent/Guardian Name	Day Time Telephone ()	Evening Phone ()	Cell Phone ()

PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name	Day Time Telephone ()	Evening Phone ()	Relationship to Girl
Home Address	City/State/Zip		

PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: _____ Telephone: () _____

Address of family PHYSICIAN: _____ City / State / Zip _____

Family Medical/Hospital INSURANCE CARRIER: _____ POLICY/GROUP NUMBER: _____

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.? Yes No

If yes, what ID number does your child use? _____ What is the HMO main phone number for emergencies? () _____

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) Check here for no known allergies

<input type="checkbox"/> Animals _____	<input type="checkbox"/> Hay Fever _____	<input type="checkbox"/> Medicines/Drugs _____
<input type="checkbox"/> Pollen _____	<input type="checkbox"/> Food _____	<input type="checkbox"/> Insect Stings _____
<input type="checkbox"/> Plants/Poison Oak _____	<input type="checkbox"/> Other (specify) _____	

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Defect/Disease _____
<input type="checkbox"/> Musculoskeletal Disorder _____	<input type="checkbox"/> Bleeding/Clotting Disorders _____	<input type="checkbox"/> Ear Infection _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Seizures/Convulsions _____	<input type="checkbox"/> Mononucleosis _____
<input type="checkbox"/> Skin Disease/MRSA _____	<input type="checkbox"/> Other (specify) _____	

Childhood Diseases: (Check those that apply and give appropriate dates)

<input type="checkbox"/> Chicken Pox _____	<input type="checkbox"/> Measles _____	<input type="checkbox"/> German Measles _____
<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Other (specify) _____	

Other Health Conditions: (Check those that apply)

<input type="checkbox"/> Attention Deficit Disorder (ADD)	<input type="checkbox"/> Down's Syndrome	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Wears Glasses/Contacts	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Emotional Disturbances	<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Sickle Cell Trait/Disease	<input type="checkbox"/> Special Dietary Regimen	<input type="checkbox"/> Dental Braces	<input type="checkbox"/> Fainting
<input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Visual Impairment	

List any current physical, mental or psychological health conditions requiring medical treatment, special restrictions or considerations: _____

List any dietary restrictions or special considerations: _____

List any previous medical treatments, operations or serious injuries, provide dates: _____

PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you **DO NOT** want your daughter to receive:

Is your daughter taking any medications? NO YES
If YES, list medication, dosage, and possible side effects.

MEDICATION	DOSAGE	POSSIBLE SIDE EFFECTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the child's name, address, dosage and frequency. Please label with girl's name and dosage any over-the-counter drugs - anti-histamines, vitamins, etc.

PART VI: IMMUNIZATION HISTORY - REQUIRED			
Vaccines		Year of Basic Immunization	Year of Last Booster
DPT	Diphtheria, Pertussis (Whooping Cough), Tetanus		
TD	Tetanus, Diphtheria		
	Tetanus		
	Oral Polio (Sabin)* TOPV		
	Injectable Polio (Salk)		
	Measles (hard measles, red measles, Rubeola)		
	Rubella (German measles, 3-day measles)		
	Tuberculin test given _____ (most recent)		
	Hepatitis B		
	Other:		

List any condition that would limit full activity and in what way: _____

Additional comments from parents/guardians: _____

PART VII: PARENT CONSENT

This health history is correct as far as I know, and my daughter has permission to engage in all prescribed activities, except as noted by me and the physician. My daughter is in good health. I give permission for my daughter to receive treatment for routine medical and/or first aid needs, as outlined in the Treatment Protocols and for the administration of prescribed medications. In the event I cannot be reached in an emergency, I give my permission for my daughter _____, to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action.

*All medications being taken are listed on the front of this form.

Parent/Guardian Signature: _____

Date: _____

AUTHORIZATION FOR PICK UP:

The following persons are authorized to pick-up my child from camp. I understand that these people, including myself, will be asked to show identification to the staff member at checkout.

Name	Relationship	Phone Number
1.		
2.		
3.		
4.		
5.		