

Medication: Provide complete information. Bring enough medication to last the entire session. All medications MUST be in pharmacy containers and appropriately labeled. Campers should be taking the same medication at the same dose for at least three months prior to arrival. All medications (including over the counter) must be checked into the Health Center.

- This camper does not take any medication.
- This camper takes routine medication (include vitamins) as follows (attach more information if needed):

Name of medication: _____	Name of medication: _____
Reason for taking: _____	Reason for taking: _____
Dose taken: _____	Dose taken: _____
How often each day? _____	How often each day? _____
Medication not taken over the summer (Please explain): _____	

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current for admission to Camp Mitre Peak.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis	*	*	*	*
Td: Tetanus, Booster	*	Must be current within past 10 yrs		
MMR: Mumps, Measles, Rubella	*	* Measles booster (required prior to 7 th grade)		
IVP/OPV: Polio	*	*	*	*
Hep B: Hepatitis B				
Hib: H. influenza, type b				
Other (i.e., Hep A, TB)				

General History: Circle “Yes” or “No” for each statement

This camper has had chicken pox	Yes	No
This camper has had mononucleosis in the past 12 months	Yes	No
This camper’s hearing is within normal ranges	Yes	No
This camper is prepared to fall asleep at night without supports such as reading or listening to music	Yes	No
This camper typically makes noise while sleeping (snores, talks in sleep, etc.)	Yes	No
This camper usually gets up at night to use the bathroom	Yes	No
This camper shares his/her bedroom at home with at least one other person	Yes	No
This camper uses contact lenses (consider bringing an extra pair) or glasses to correct vision	Yes	No
This camper is free of illness, injury or surgery which would affect program participant	Yes	No
This camper knows about menstruation and/or has a normal menstrual history	Yes	No
Additional information about any of the items above: _____		

Name of camper’s pediatrician: _____ Office phone: (____) _____

Name of camper’s orthodontist: _____ Office Phone: (____) _____

Name of camper’s dentist: _____ Office Phone: (____) _____

Any additional doctors camper is seeing: _____ Office Phone: (____) _____

Mental and Emotional Health: Circle “Yes” or “No” for each statement

This camper has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD	Yes	No
This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder.....	Yes	No
This camper has an emotional health concern.....	Yes	No
This camper has a learning disability.....	Yes	No
This camper has seen or is currently seeing a professional to address mental/emotional health concerns.....	Yes	No

If “Yes” was the answer to any question in this section, please attach a statement from your physician or psychiatrist which:

- (a) Describes the concern and camper’s management plan (including medications),
- (b) Describes the behaviors which would indicate to our staff that your camper needs professional referral, and
- (c) Provides a recommendation for participation in the Camp Mitre Peak Program.

What have we forgotten to ask that will help your daughter? Provide additional information about your child’s health which may have been neglected on this form. We are particularly interested in information which has impact upon your child’s ability to fully participate in our program.

Billing Information for Health Care: There is generally no charge for health care received from the provider in the camp. Include a copy of an insurance card if appropriate. Copy both sides of the card so addresses and telephone numbers are available. Campers are covered by Girl Scouts of the USA up to \$125.00. For any accident or illness occurring during camp.

Insurance Company: _____

Address: _____

Policy Number: _____ Group Number: _____

Name of Employee or Insured: _____ Relation to Participant: _____

Parent Contact Information: We will call in an emergency or if we have questions about your child. Provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We assume you have spoken with these individuals and they are willing to assist should the need arise.

Parent/Guardian

Name: _____

Daytime _____ Evening _____

Telephone: (____) _____ Telephone: (____) _____

Cell Phone: (____) _____

Address: _____

Alternate Contact: _____ Telephone: (____) _____ Relationship to camper _____

Alternate Contact: _____ Telephone: (____) _____ Relationship to camper _____

IMPORTANT-THIS BOX MUST BE COMPLETE FOR ATTENDANCE *

Permission to Provide Necessary Treatment or Emergency Care: I hereby give my permission to the medical personnel selected by the Girl Scouts of the Permian Basin to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand and agree to abide by the restrictions placed on my camp activities. I also understand that Girl Scouts of the Permian Basin are committed to complying with all the rules and regulations relating to HIPPA. I understand that all campers and staff health information will be treated in a confidential manner by all health care providers at the camp. I understand that it may be necessary in some circumstances for the health care staff to share confidential health information about your child or staff member in order to provide a safe and health environment.

Signature of Parent/Guardian
Or Adult Camper/Staffer: _____ Witness: _____ Date: _____

** If for religious reasons you cannot sign this, contact the Camp Registrar for a legal waiver which must be signed for attendance.*

Doctor's Examination Form

**HAVE YOUR PHYSICIAN OR NURSE PRACTITIONER COMPLETE THIS FORM.
THIS FORM IS REQUIRED, AND MUST BE SUBMITTED AT LEAST TWO WEEKS PRIOR TO ARRIVAL.**

Medical Recommendation Form (Mandatory)

To Physicians and Nurse Practitioners: This child has enrolled in a summer residential program of the Girl Scouts of the Permian Basin. The program includes physical activity such as swimming, hiking, backpacking, horseback riding, and rappelling. Our healthcare staff uses your information to help meet the health needs of the person described.

Print MD/NP Name: _____	City and State: _____
Office Telephone (____) _____	Date this form was completed: _____

Camper's Name _____

Session _____ Age _____ Birth Date _____

Social Security # _____ Height _____ Weight _____

Daytime Phone # (____) _____ Evening Phone # (____) _____ Cell Phone # (____) _____

Street Address _____

City, State, Zip _____

This child is under the care of a physician for the following reason (s): _____

Describe the treatment(s) to be continued at Camp Mitre Peak for this child: _____

Prescription medication(s) which this person should take while at camp is/are (provide medical order for administration): _____

This person is allergic to: _____

Should exposure occur, how should the allergic reaction be treated? If this is an anaphylactic response, will this child bring an epinephrine device? _____

Describe significant physical findings regarding this camper AND/OR describe any limitations which impact the child's participation in our program: _____

These medications, stocked in the Camp Mitre Peak Health Center, are used to manage illness or injury concerns and dispensed as directed via medical protocols signed by the program's supervising physician. Cross out those which are contraindicated for this camper.

Acetaminophen	Diphenhydramine	Kaolin-Pectin	Triple antibiotic cream
Bismuth Chew Tabs	Guaifenesin DM	Nix	Pseudoephedrine
Calamine Lotion	Ibuprofen	Tinactin	Silver Sulfadiazine
Cholorpheniramine Maleate	Kaopectate	Senna	NightTime cold Formula
Chamomile Tea	Generic Cough Drops	Aloe	Benedryl

We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments. Thank you for helping provide a successful Camp Mitre Peak experience for this child!

___ Additional Sheet Attached.

Doctor's Signature: _____ **Must be signed and dated by**

Date of exam: _____ **Doctor/Physician's Assist.**