girl scouts of northern california

Staff Health History Record with Physical

Please return form to: Camp Butano Creek, 1771 Dawn St., Livermore, CA 94550, **by MAY 18th**
Please download and save this form before entering the information. You may also choose to print and complete the form manually, *please print clearly*.

Staff *"Camp"* Name: _____

Staff Name: _____ Birthdate (month/ date/ year): _____ Gender: _____

Address (street address, city/state, zip): _____

Cell phone: _____ Daytime phone: _____ Evening Phone: _____

Parent/Legal Guardian (if staff under 18): _____ Phone: _____

Medical and Insurance Information:

Name of Family DENTIST: _____ Phone: _____

Name of Family PHYSICIAN/Clinic: _____ Phone: _____

Name of Carrier: _____Policy#: _____

Insured's Name: _____ Member ID#: _____

Insured's Employer (if insurance is through work):_____

Others who could be contacted to authorize medical treatment:

Name: _____ Relationship to staff_____ Phone: _____

Name: _____ Relationship to staff_____ Phone: _____

PART A:	**Check those that apply.** Specify cause and nature of reaction (*i.e., Penicillin causes hives*) ☐NO ALLERGIES (skip this section)		
ALLERGIES	☐Animals:	☐ Insect Stings:	☐Plants/Trees:
	☐Hay fever:	☐ Pollen:	☐Poison Oak:
	☐Food:		
	☐Medicine / Drugs:		
	☐OTHER:		
	In case of an allergic reaction, respond by:		

PART B:	**Check those that apply**		
PAST MEDICAL HISTORY AND DISEASE HISTORY	☐ ADD / ADHD	☐ Ear Infection	☐ Mumps
	☐ Arthritis	☐ Eating Disorders	☐ Muscle Disease / Disorder
	☐ Asthma	☐ Emotional Disturbances	☐ Nervous System Disorder
	☐ Anxiety☐	☐ Epilepsy	☐ Nosebleeds
	☐ Athlete's Foot	☐ Eyes: Contact Lenses	☐ Orthodontic/Dental Appliances
	☐ Behavioral Changes	☐ Eyes: Glasses	☐ Physical Disabilities
	☐ Bed Wetting	☐ Fainting	☐ Runny Nose
	☐ Bipolar Disorder	☐ German Measles	☐ Seizures
	☐ Bleeding / Clotting Disorder	☐ Hay fever	☐ Sickle Cell Trait or Disease
	☐ Bronchitis	☐ Headaches, frequent	☐ Sinusitis
	☐ Chicken Pox	☐ Hearing Impairment	☐ Skeletal Disease / Disorder
	☐ Concussion	☐ Heart Defect / Disease	☐ Skin Conditions
	☐ Constipation	☐ Hepatitis A / B / C	☐ Sleep Disturbance
	☐ Convulsions	☐ Hypertension	☐ Sleepwalking
	☐ Cough	☐ Kidney Disease	☐ Sore Throat
	☐ COVID-19	☐ Measles	☐ Special Dietary Regiment
	☐ Depression	☐ Menstrual Complications	☐ Stomach Upsets
	☐ Diabetes	☐ Migraines	☐ Urinary Tract Infection
	☐ Diarrhea	☐ Mononucleosis	☐ Visual Impairments
	☐ Down's Syndrome	☐ Motion Sickness	
	☐ OTHER:		

PLEASE EXPLAIN:

- Indicate any information useful to the adult in charge in relation to any of the health conditions chosen in **PART B**.
- Indicate any activity to be encouraged or restricted.

Dietary Needs / Restrictions:

PART C:	**Immunization**	**Year Primary Series Completed**	**Year of Last Booster**
IMMUNIZATIONS	Chicken Pox		
	COVID-19		
	D.T.P.		
	Diphtheria		
	Hepatitis B		
	Hib (*Haemophilus influenza B)*		
	Measles		
	Mumps		
	Oral Polio		
	Pertussis *(whooping cough)*		
	Rubella (*German Measles)*		
	Td *(tetanus/diphtheria)*		
	Tetanus		
	Tuberculin Test Result **(most recent)**		
	OTHER:		

☐ **All vaccinations are up to date.**

MEDICATIONS	**Listed are all prescribed medication(s) that I will routinely take. (see last page for additional medication spots)**			
	Medication Name		**Dosage**	**How often?**
Please initial below, if applicable	*Staff:* _____ will self-administer the following medication(s).			
		Medication Name	**Dosage**	**How often?**
*				
*	☐ Diabetic Medication			
*	☐ Epi-pen			
*	☐ OTHER:			

Over-the-Counter Medication(s):

Over-the-counter medications will be used to treat routine illness per treatment protocols. Acetaminophen is used in place of aspirin.

I can have: ☐ Pain medications ☐ Cough syrup ☐ Antibiotic ointment ☐ Fever reducer ☐ Digestive relief ☐ Antihistamines

☐ OTHER: _____

I **CANNOT** have: _____

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Staff Health History Record with Physical

Health Information Privacy Statement:

The Staff Health Form is for health care concerns during camp. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the camp. Minimal necessary information may be shared with camp staff/volunteer(s) in order to provide adequate participant safety and health care. The health history record will be retained by Girl Scouts of Northern California until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of U-18 Staff. Access to the information will be limited, but copies may be requested from the camp, by the camper or their legal representative.

Transportation Release:

I authorize transportation for myself or my child (if staff under-18) by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of myself or my child (if U-18 staff). It is my expressed intention to hold Girl Scouts of Northern California harmless for any and all injuries, death or damages arising from or any way related to any such transportation.

Consent to Treat:

I hereby give permission to the physician selected [by the camp nurse / First aider] to order x-rays, routine tests and treatment for the health of myself or my child (U-18 staff), in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the first aider/trip coordinator to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for myself (if I am unable to do so) or my child (U-18 staff) as named above. I also give my consent for myself or my child (U-18 staff) to be tested for the COVID-19 virus while participating at Butano Creek Sleep Away Camp by the camp nurse/ First Aider, using an over-the-counter test, should myself or my child (U-18 staff) become ill or exhibit COVID symptoms. If permission is not given for COVID-19 testing, I agree to leave camp or to pick up my child (U-18 staff) as soon as possible after the Camp Nurse/First Aider has contacted me. For U-18 Staff, it is understood that every attempt will be made to contact me, or the emergency contact person listed on this form, before taking this action.

The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to Camp Staff, drivers, medical personnel, etc.

FOR STAFF 18 & older -Participant Authorization:

To the best of my knowledge this health history is correct. I am able to engage in all planned camp activities except as noted by the examining physician. By volunteering to staff at Butano Creek Sleep Away Camp and Girl Scout activities: a) I acknowledge that an inherent risk of exposure to COVID-19 exists while attending and participating in all camp activities; and b) I am voluntarily assuming all risks related to exposure to COVID-19 and agree not to hold Butano Creek Sleep Away Camp and Girl Scouts of Northern California, or any of its directors, employees, agents or volunteers, liable for any illness or injury. I have read the above procedures for handling the health history form information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Signature of Participant **Date**

Print Name of Participant **Phone** **Email Address**

FOR U-18 STAFF - Parent's / Legal Guardian Authorization:

This health history is correct so far as I know, and the person herein described has permission to engage in all planned activities except as noted by the examining physician or me. By allowing my child to participate in Butano Creek Sleep Away Camp and Girl Scout activities: a) I acknowledge that an inherent risk of exposure to COVID-19 exists while attending and participating in all camp activities; and b) I am voluntarily assuming all risks related to exposure to COVID-19 and agree not to hold Butano Creek Sleep Away Camp and Girl Scouts of Northern California, or any of its directors, employees, agents or volunteers, liable for any illness or injury. I have read the above procedures for handling the health history form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature of Parent/Legal Guardian **Relationship to Camper** **Date**

Print Name of Parent/Legal Guardian **Phone** **Email Address**

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Staff Health History Record with Physical

Record of Health Examination

All participants attending or working at a sleepaway camp are required to have a completed health examination by a: **LICENSED PHYSICIAN (MD); PHYSICIAN ASSISTANT (PA); or NURSE PRACTIONER (NP)** acting under the supervision of a licensed MD may also complete and sign the health examination.

The health exam must be completed within 12 months of the registered camp session. **DUE DATE for ALL health records for participants is MAY 18TH.** If your physical cannot be completed by this date, you will be able to continue to submit/upload this form, up to 1 week prior to the start of the camp session, with Camp Director or Camp Nurse approval.

Participant Name: _____

To be completed by MD, PA or NP:

I have examined the above applicant within the past 12 months. **Date of exam:** _____

In my opinion, the above participant's condition ☐ Does ☐ Does NOT preclude their participation in an outdoor camp program.

Activities to be limited: _____

Current Treatment: (including any medications): _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____

Please note that a Tuberculin test is only required for ALL kitchen staff, Cooks & Dining Hall staff. *Required within 24-months of camp session.*

TUBERCULIN TEST: Skin Test _____ X-ray_____ Result_____

Medical Office Stamp or Address

Name of MD, PA, or NP: _____

Signature of MD, PA, or NP: _____

Phone: _____

Date Signed: _____

OPTIONAL PAGE FOR ADDITIONAL MEDICATIONS

Please list all medications you are bringing to camp, as the list will generate the medication list for administration of medications during camp.

ADDITIONAL MEDICATIONS

Listed are all prescribed medication(s) that I will routinely takes not listed on page 2		
Medication Name	**Dosage**	**How often?**

Medication List generated from above. For use during camp.

Camp Name		**Circle**	**1 2**	**Unit**	
Staff Name		**Session**	**3**		

Allergies	☐ **No Allergies**		
Animals ☐	Hay Fever☐	Other☐	
Plants/Trees ☐	Pollen ☐	Poison Oak ☐	
Insect Stings☐	Medicine/Drugs☐	Food☐	
Can have the following:	☐ Pain medications ☐ Cough syrup ☐ Antibiotic ointment ☐ Fever reducer ☐ Digestive relief ☐ Antihistamines ☐ OTHER:		

Please complete a separate line for each Prescribed Medication and Vitamin/Supplement taken on a regular basis as well as any OTCs that will be brought from Home include dosage! Any OTC's you are bring that you only take when needed please indicated that by putting PRN after its name.

MEDICATIONS

NAME/DOSE/FREQUENCY	DATE / HOUR	PC 1	PC 2	D 1	D 2	D 3	D 4	D 5	D 6	D 7	D 8

Medication List generated from above. For use during camp.

ADDITIONAL MEDICATIONS

NAME/DOSE/FREQUENCY	DATE										
	HOUR	PC 1	PC 2	D 1	D 2	D 3	D 4	D 5	D 6	D 7	D 8

Medication List generated from above. For use during camp.

ADDITIONAL MEDICATIONS

Medication List generated from above. For use during camp.

ADDITIONAL MEDICATIONS

NAME/DOSE/FREQUENCY	DATE										
	HOUR	PC 1	PC 2	D 1	D 2	D 3	D 4	D 5	D 6	D 7	D 8