# *Day Camp Camper Health History- Girl Scouts of Northern California*

Name

Unit #

Bus Color

Date of Birth

First Last circle one

Camper Name _____ Female Male

Address _____

Phone Number _____ Birth date _____ Age at camp _____

Troop # _____ Grade in fall _____

Parent/Guardian #1 Name_____

Daytime Phone _____ Alternate/Cell Phone _____

Parent/Guardian #2 Name _____

Daytime Phone _____ Alternate/Cell Phone _____

Emergency Contact Other than Parents/Guardians _____

Daytime Phone _____ Alternate/Cell Phone _____

**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? _____

**Please check all of the illnesses/injuries/conditions that have occurred in the past 6 months**:

___Asthma
___Allergies
___Attention deficit disorder
___Bleeding/clotting disorder
___Braces
___Chest pain
___Chicken Pox
___Diabetes
___Ear Infection
___Fainting
___Frequent headaches
___Head injury
___Hearing loss
___Heart Defect/Disease
___Hospitalization
___Hypertension
___Joint injury
___Learning disability
___Lyme disease
___Mononucleosis
___Motion sickness
___Muscle injury
___Seizures
___Skeletal injury
___Surgery
___Vision difficulties/wears glasses

**Please provide explanations for any checked boxes.**

**Allergies- Please list all known and describe reaction.**

Allergies to medication:

_____ Reaction _____

Allergies to food:

_____ Reaction _____

Other Allergies:

_____ Reaction _____

**Please list any restrictions to food or activity for your child.**

_____

_____

**Please share any other information you feel the camp staff should have about your child's physical, emotional, or mental health.**

_____

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