



# Camper Health & Information Permission Form

Dear Parent/Caregiver,

To help us prepare for your camper to have the best camp experience possible and to ensure her well-being, this form must be completed. If your camper is registered for a session at more than one camp, you must provide a copy of the form to each camp.

An online version of this form is available. If you choose to fill out a hard copy, please mail this form to GSNI-M Camps, address at the bottom, before May 20. If the form will be received after this day, do not mail it, please arrange for a copy to be given directly to the camp director as soon as possible **and** bring a copy to camp with your camper.

If your camper has special dietary or medical needs, please contact your Camp Director at least 4 weeks prior to your camp session to discuss those needs.

For more information or questions, please contact: Your Camp Director—see individual information on [gsnim.org](http://gsnim.org) or contact the Answer Center at 800-283-4812 ext. 2 or [frontdesk@gsnim.org](mailto:frontdesk@gsnim.org).

**ALL Campers must complete Camper Info and Health History, and Permissions form—all four (4) pages. Add additional pages as needed to share complete information. All information will be held in strict confidence and will only be shared with camp staff who need the information.**

## Camper Info and Healthy History (to be completed for all campers)

Camper Name \_\_\_\_\_ Nickname \_\_\_\_\_

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_ age: \_\_\_\_\_ Current or completed grade \_\_\_\_\_ Camp Buddy \_\_\_\_\_

Session Name(s) and dates \_\_\_\_\_

Were you in a troop this past year?  No  Yes Troop # \_\_\_\_\_ Is your troop continuing next year?  Yes  No

Have you been to Girl Scout Camp before:  No  Yes:  Day  Sleep away (week long)  Sleep away (Mini)  Weekend

### Custodial Care Information

My camper is under the custodial care of (check one):

- Both parents  Mother only  Father only  
 Other

Name of Parent/Caregiver with legal custody to be contacted in case of illness or injury \_\_\_\_\_

Relationship to camper \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone/other \_\_\_\_\_  
Second parent/guardian or other emergency contact name \_\_\_\_\_

Relationship to camper \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone/other \_\_\_\_\_  
Additional emergency contact (person to contact if parent/guardian cannot be reached in emergency)

Name \_\_\_\_\_

Phone Numbers \_\_\_\_\_

# Health History

This information must be completed by the parent/guardian or adult camper or staff member to provide camp health care personnel with the background to provide appropriate care.

## General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- |   |   |
|---|---|
| 1. Ever been hospitalized..... <input type="checkbox"/> Yes <input type="checkbox"/> No           | 12. Had fainting or dizziness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                          |
| 2. Ever had surgery..... <input type="checkbox"/> Yes <input type="checkbox"/> No                 | 13. Passed out/had chest pain during exercise?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| 3. Have recurring/chronic illness?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  | 14. Had mononucleosis during the last 12 mos.?..... <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| 4. Had a recent infectious disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. If female, have problems with periods/menstruation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?..... <input type="checkbox"/> Yes <input type="checkbox"/> No             | 16. Have problems with falling asleep/sleepwalking?..... <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| 6. Ever had back joint problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No    | 17. Had asthma/wheezing/shortness of breath?..... <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| 7. Have diabetes?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 18. Have a history of bedwetting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| 8. Had seizures?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                    | 19. Have problems with diarrhea/constipation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| 9. Had headaches?..... <input type="checkbox"/> Yes <input type="checkbox"/> No                   | 20. Wear glasses, contacts, or protective eyewear?..... <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| 10. Have any skin problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No         | 21. Traveled outside the country in the past 9 months?..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 11. Have Allergies..... <input type="checkbox"/> Yes <input type="checkbox"/> No                  | 22. Eat a Special Diet..... <input type="checkbox"/> Yes <input type="checkbox"/> No                                  |

Please explain "Yes" answers in the space below, noting the number of questions. For travel outside the country, please name the countries visited and dates of travel. In case of allergies describe reaction and management of the reaction.

## Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

Has the camper:

- Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?.....Yes No
- Ever been treated for emotional or behavioral difficulties or an eating disorder?.....Yes No
- During the last 12 months, seen a professional to address mental/emotional health concerns?.....Yes No
- Had a significant life event that continues to affect the camper's life?.....Yes No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)
- Does your camper have any other special needs (for example, a wheelchair, walker, interpreter).....Yes No
- Other special needs not listed?.....Yes No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for any additional information.

## Immunizations

I attest that all immunizations required for school are up to date.....Yes No

Please provide the actual date (Month/Year) of Tetanus shot or booster (dT) or (Tdap)\* \_\_\_\_\_ (Month/Year)

\*Please contact the GSNI-M Council Office for Immunization exemption form, if needed.

Date of last physical exam (include year) \_\_\_\_\_

Camper's Physician \_\_\_\_\_ Phone \_\_\_\_\_

## Medication

Please list all medications (including over-the-counter or non-prescription medications) the person takes routinely. Bring enough medication, in the original packaging/bottle with its prescription or over-the-counter label, to last for the entire camp session. By completing the following information, you are giving permission for camp staff to administer the following:

This camper: Takes NO medications on a routine basis Takes prescription/over-the counter medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

**Attach additional pages for more medications or additional medication information**



By checking the boxes below, I also give consent to...

**Outcomes measurement:**

Your camper will be asked to take a short survey to measure our success in meeting Girl Scout outcomes. Your camper's opinions will be anonymous. This information is important to evaluating the Girl Scout program to make improvements and help with obtaining funding for camperships.

**Material release:**

I consent that photographs, artwork, audio, video, or writing of my camper (without name identification) may be used by Girl Scouts of Northern Indiana-Michiana, its assigns or successors, in whatever way they desire, including print materials, television, social media, and forms of storage, retrieval, and reproduction of the information or images; furthermore, I hereby consent that such information, photographs, videos, and the plates and/or tapes from which they are made shall be their property, and they shall have the right to duplicate, reproduce, sell, and make other uses of such information, photographs, videos, recordings, and plates as they may desire, free and clear of any claim whatsoever on my part.

**COVID Informed Consent Acknowledgement:**

I hereby attest that I have been informed of the following information pertaining to COVID-19:

- COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact.
- Individuals with serious underlying medical conditions are at a higher risk for severe illness.
- As with any social activity, participation in in-person Girl Scouts activities could present the risk of contracting COVID-19. While Girl Scouts of Northern Indiana-Michiana (GSNI-M) takes every safety and preventative precaution, GSNI-M can in no way warrant that COVID-19 infection will not occur through participation in GSNI-M programs or troop activities. Participation may lead to exposure, illness, or quarantine requirements.

I agree that:

- On behalf of myself and my participating children, I will comply with the most recent guidance and recommendations issued by the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), and my local state agency or municipality for slowing the transmission of COVID-19.
- Neither I nor my participating children shall visit or utilize the facilities, services, and/or programs of the Girl Scout Council within 14 days after (i) returning from highly-impacted areas listed on the Indiana Department of Health and Michigan Department of Health high exposure zones, (ii) exposure to any person returning from areas subject to a CDC Level 3 Travel Health Notice, (iii) exposure to any person who has a suspected or confirmed case of COVID-19, or (iv) exposure to any other risk identified by the most recent guidelines or recommendations or situation delineated by WHO, the CDC or my state public health agency or municipality.
- Neither I nor my participating children shall participate in, visit or utilize the facilities, services, and/or programs of the Girl Scout Council if I, he, or she (i) experience(s) symptoms of COVID-19, including, without limitation, fever, cough, loss of sense of taste or smell, or shortness of breath, or (ii) has a suspected or diagnosed/confirmed case of COVID-19.

This Health History is correct as far as I know, and the person herein describes has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the camp to provide routine healthcare and administer medications as indicated on Page 2 and to medical personnel selected by the camp to order x-rays, routine test, and treatment related to the health of my child for both routine healthcare and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child. I understand the information on this form will be share on a "need to know" basis and with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record for providers who may treat my child, and these providers may talk with the program's staff about my child's health status.

Custodial Parent/Caregiver Signature \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities.

Camper Signature \_\_\_\_\_ Date \_\_\_\_\_