	Program Date:		Program Name	<u> </u>					
Health History: Physical Examination: Medication Log:	If attending a resident camp program, mail this completed form by June 6 th to: Girl Scouts of Michigan Shore to Shore Attention: Camp Forms 3275 Walker Ave NW Grand Rapids, MI 49544 If registering for resident camp program after June 6 th mail completed form to above address at least two weeks prior to your camper's session.								
PARTICIPANT INFOR	RMATION								
Participant Na	me		Home Phone	Age	e	Birth Date _	/ /		
Mailing Addres	SS		City	Sta	te	Zip Code			
If a minor: Parent/Guardian #1's Name				Parent/Guardian #1's Name					
Pa	Parent/Guardian #1's Phone								
EMERGENCY CONT	ACT INFORMATIO	NS (if parti	cipant is a minor, please list a	non-parent/guardi	an conta	ict)			
Person to be r	Relationship to camper								
Phone #1									
INSURANCE INFORM				_					
Insurance Con	Members Se	rvices Ph	none						
Insurance CompanyAddress									
HEALTH INFORMAT				_ Name of misc	cu		rivarriber		
 Asthma? Diabetes? Seizures/ep Frequent ex Frequent so Sinusitis? Bronchitis? Fainting/diz Stomach up Constipatio Bed wetting Urinary trace 	□Yes □Yes ar infections? □Yes are throats? □Yes □Yes □Yes □Yes □xiness? □Yes axiness? □Yes axiness? □Yes axiness? □Yes axiness? □Yes	No	plain "Yes" answers below and 13. Sleeping disorder/sleep wal 14, Heart defect/disease? 15. Bleeding/clotting disorders' 16. Hypertension? 17. Recent infectious disease? 18. Chronic/reoccurring illness' 19. Skin conditions? 20. ADD/ADHD? 21. Autism Spectrum Disorder? 22. Emotional disability? 23. Learning disability? 24. Physical disability?	king?	No	ons needed. 25. Visual disability 26. Deaf/hard of he 27. Behavioral prob 28. Eating Disorders 29. Has this person a. If not, has she been b. If so, is her menstru 30. Operations/seri 31. Other diseases/	earing? blems? s? menstruated? told about it? ual history normal? ious injury?	☐Yes☐Yes☐Yes☐Yes☐Yes☐Yes☐Yes☐Yes☐Yes☐Yes	☐ No ☐ No
DIETARY RESTRICTIONS Please specify any accommodations needed □Vegetarian □ Vegan □Gluten-free □ Lactose-free □ Other				ALLERGIES Please explain severity of allergies (contact, ingestion, smell, etc. □ Drug □ Plant /Pollen/Insects □ Food □ Other					
OVER THE COUNT Tylenol/Acetam Advil/Ibuprofer Sudafed/decon Benadryl/antihi Tums/antacid Rubitussin/exp Calamine lotior Cough drops HEALTH FORMS A	gestant istamine ectorant ARE CONSIDERED ERNAMENT CAMP	The staff med info heal form Acce their the med	LTH INFORMATION PRIVACY STA Health History Form is for health f/volunteers whose job includes p dical records will be held in limited rmation may be shared with even lth care. The health form will be r ns/records with noted treatment ess to the information will be limit r legal representative. I have read release of any records necessary in dical treatment be given if needed to health history is complete and a	care concerns at the rocessing or using the access by the heal at staff and volunteer etained by Girl Scowill be retained for ted, but copies may at the above proced for treatment, refer I for illness or injury	this inforn th care su ers in orde uts of Mic seven yea be reque ures for harral, billing	mation for the benefit of upervisor of the specific er to provide adequate p chigan or GSUSA until it is ars past the age of matu ested from the event spot andling the health form g or insurance purposes.	f the participan event. Minima participant safe is destroyed. A urity of the part onsor, by the p information a . I authorize er	nt. All al necess ety and All ticipant. articipar nd I agreemergence	nt or ee to

Location of Program

Camp Anna Behrens Camp Sakakawea

RECORD AND RETURNED.

Signature of self or Parent/Guardian (if minor)_

Date