

Rancho Cortez Girls Camp Emergency Contact and Health Record

Child's Name	Date of Birth		M	F
			Sex	
Parent's/Guardian's Name	Parent's/Guardian's Name			
()	()	()	()	
Home Phone	Work Phone	Home Phone	Work Phone	
Address	Address			
City, ST ZIP Code	City, ST ZIP Code			

Alternative Emergency Contacts

Primary Emergency Contact	Secondary Emergency Contact
()	()
Home Phone	Work Phone
()	()
Home Phone	Work Phone
Address	Address
City, ST ZIP Code	City, ST ZIP Code

Medical Information

Physician's Name	Phone Number
Insurance Company	Policy ID Number and Group Number
Insurance Company Member Services Phone Number	Insurance Company Address

Allergies/Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the even that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature	Date
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I give permission for my child to go on field trips. I release Rancho Cortez and individuals from liability in case off accident during activities related to Rancho Cortez.

Parent's/Guardian's Signature	Date
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Witness Signature	Date
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Health History – please describe conditions and provide dates

Operations or serious injuries: _____

Hospitalization: _____

Other Diseases/disabilities: _____

Comments – where applicable

Fainting: _____

Bed Wetting: _____

Constipation: _____

Sleep Disturbances: _____

Menstrual Cramps: _____

Nosebleeds: _____

Emotional Disturbances: _____

Specific Activities to be Encouraged: _____

Special Dietary Regimen: _____

Check All That Apply

Childhood illness:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> German Measles <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney
Allergies:	<input type="checkbox"/> Animals – list: <input type="checkbox"/> Food – list: <input type="checkbox"/> Hay Fever – list: <input type="checkbox"/> Insect Stings – list: <input type="checkbox"/> Medicine Drugs – list: <input type="checkbox"/> Plants – list: <input type="checkbox"/> Pollen – list: <input type="checkbox"/> Other – list:
Chronic or Reoccurring Illnesses:	<input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other – list:
Suggestions from Parent:	<input type="checkbox"/> Yes, my daughter has permission to take or use the following: <input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Sudafed/Decongestant <input type="checkbox"/> Benadryl/Antihistamine <input type="checkbox"/> Peto Bismol <input type="checkbox"/> Tums/Anti-acid <input type="checkbox"/> Robitussin/Expectorant <input type="checkbox"/> Swimmer's Ear/Alcohol-Vinegar Solution

Record of Immunization

Immunization	Year Primary Series Completed	Year of Last Booster
<input type="checkbox"/> DTap: Diphtheria Pertussis (Whooping Cough) Tetanus (with in last 10 years)		
<input type="checkbox"/> Td		
<input type="checkbox"/> Oral Polio/IPV		
<input type="checkbox"/> Measles		
<input type="checkbox"/> Mumps		
<input type="checkbox"/> Rubella		
<input type="checkbox"/> HiB		
<input type="checkbox"/> HepB		
<input type="checkbox"/> Tuberculin Test	Year Last Given:	Result:
<input type="checkbox"/> Typhoid and Paratyphoid		
<input type="checkbox"/> Cholera		
<input type="checkbox"/> Yellow Fever		
<input type="checkbox"/> Typhus		
<input type="checkbox"/> Rocky Mountain Spotted Fever		

Health Information Privacy Statement:

The GIRL HEALTH EXAMINATION RECORD is for health care concerns at the specified event only. 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 specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council until it is destroyed. Access to information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

I have read the above procedures for handling health form information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

SIGNATURE: _____
(Parent or Guardian)

DATE: _____

Please attach any additional information necessary.