Girl Scouts of California's Central Coast

CONSENT TO PROVIDE MEDICATION TO A MINOR

Name of Minor _____

***** ALL medications will be dispensed by the Day Camp Health Supervisor *****

1. My child is allergic to the following medications: _____

_____

2. **Medication brought from home to be given at the Day Camp** -- My child takes the medication listed below on a regular basis (include such things as allergy and menstrual cramp relief medications).

Mediation	Purpose	Usual Dosage	Schedule	Notes

If a prescription does not have your child's name as the designated patient, we cannot administer the medication.

Please initial EACH item you will permit to be administered. No medication will be administered without permission.

Over the Counter Medication	**Purpose**
_____Acetaminophen	To reduce pain or fever (i.e. Tylenol, Anacin II)
____ Ibuprofen	an anti-inflammatory for swelling or fever (i.e. Advil, Motrin)
____Throat Lozenges	Sore Throat
____Antibiotic Ointment	Cuts or scratches (i.e. Neosporin)
____Eye Rinse	Eye irritation
____Caladryl lotion	To sooth insect bites
____Anti-Acid Chewable	For slight upset stomachs
____Hydrocortisone Cream or spray	Rashes
____Hydrogen Peroxide	Cleaning wounds
____Lip Balm	To sooth chapped lips
_____Sunscreen	To avoid sunburns
____Bug Spray	To avoid bug bites

NO MEDICATION WILL BE DISPENSED WITHOUT PARENT/GUARDIAN SIGNATURE

Signature _____ Date _____

Girl Scout of California's Central Coast

EMERGENCY MEDICAL RELEASE AND HEALTH RECORD FOR DAY CAMP

CHILD'S FULL NAME:_____

Date of Birth: _____

I (we) the undersigned parent(s) or legal guardian of _____minor(s), do hereby authorize and consent to any x-ray examination, anesthetic, medical surgical diagnosis rendered under the general or special supervision of any member of the medical staff and Emergency Department staff licensed under the provisions of the medicine practice act or a dentist licensed under the provisions of dental practice act, and/or the staff of any acute general hospital holding a current license to operate a hospital from the state of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, or treatment of hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to tendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.
This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California.

HEALTH RECORD: My child is subject to or has the following (please check):

- ☐ **Frequent colds/Sore throat**
- ☐ **Serious plant poisoning (such as poison oak)**
- ☐ **Stomach aches**
- ☐ **Allergies: _____**
- ☐ **Asthma**
- ☐ **Hay fever**
- ☐ **Attention Deficit Disorder**
- ☐ **Sensitivity to face make-up/hair spray**
- ☐ **Bronchitis/Sinusitis**
- ☐ **Sleep walking**
- ☐ **Convulsions/Epilepsy**
- ☐ **Heart trouble**
- ☐ **Diabetes**
- ☐ **Menstruation**
- ☐ **Other: _____**

List any limitations:

_____

_____

Date of last vaccination: Tetanus/Diphtheria:_____Measles:_____Polio:_____

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Family Doctor: _____ Phone: _____

Insurance Carrier: _____Group/Policy number: _____

Home Phone: _____Work Phone: _____

Address: _____City:_____Zip:_____

HEALTH STATEMENT: I accept responsibility for being sure that _____ is in good health when she/he goes to camp. If the camper has had an operation or serious illness since last examination, I will provide written permission from our doctor.

Signature of parent or guardian: _____ Date: _____

Girl Scout of California's Central Coast

Adult Volunteer Medical and Health Record For Day Camp

Volunteer's FULL NAME:_____

Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

HEALTH RECORD:

Please list any significant health concerns that you currently have or are being treated for by a physician:

_____

_____

_____

List any allergies you have, including medications: _____

_____

_____

List any limitations you have:

_____

_____

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

Family Doctor: _____ Phone: _____

Insurance Carrier: _____Group/Policy number: _____

Home Phone: _____Work Phone: _____

Address: _____City:_____Zip:_____

I have disclosed any medical conditions that I am being treated for by a physician, as well as any allergies that I have.

Signature: _____ Date: _____

*Please print and fill out this form to be turned in on the first day you volunteer at camp.