Medical Information 2014

PLEASE READ THIS MESSAGE EVEN IF YOUR CHILD DOES NOT TAKE ANY PRESCRIBED MEDICATION. POLICIES REGARDING THE ADMINISTRATION OF NON-PRESCRIBED MEDICATION ARE INCLUDED AS WELL.

Dear Parents/Caregivers,

This letter is designed to give you information regarding the administration of medication at Sandy Ridge. During Check-In **YOU MUST WAIT IN LINE AND GIVE MEDICATION DIRECTLY TO THE HEALTH SUPERVISOR.** During Check-In you will be able to discuss any medical questions you may have and give any special instructions about the administration of medicine to your camper. An individual Medication Consent Form must be completed for any medication provided. You will be asked to review this log sheet with the Health Supervisor. The following guidelines have been established to ensure the safe and proper administration of medicine.

IF YOU ARE BRINGING YOUR OWN MEDICATION:

1. Each medication, including over-the counter medication and vitamins, must be in its original container with the proper label. It helps during Check-In if the container is in a sealable plastic bag and labeled with dosage instructions as well.

2. For prescription medications, the prescription must be current (within one year), in the camper's name and with the proper instructions. **If the instructions/dosages have changed, you must provide a doctor's note stating the new instructions/dosages.**

3. Please send only the amount of medication the camper will need during her time at Sandy Ridge. Do not send extra pills/liquid medicine.

4. If your camper needs special equipment (e.g. a certain cup or straw) or food (e.g. applesauce, pudding or yogurt) to take medication, please bring these to camp in the original container, labeled with the camper's name.

5. If the medication causes side effects, such as drowsiness, dizziness, or altered state, please contact the Camp Director at 843-479-6814 or chuckiler@girlscoutsesc.org to discuss prior to attending camp.

OVER-THE-COUNTER MEDICATION ADMINISTRATION:

In addition to the medications you provide for your camper, the Health Supervisor has standing orders to administer certain over-the-counter-medications. These medications are listed on the attached page for your review. In most cases the Health Supervisor will not call when these medications are given. However, you would be notified right away if your camper became seriously ill or did not respond to over-the-counter medication. The administration of all medications is documented in the camp's treatment log.

NOTIFICATION PROCEDURES:

Sandy Ridge contacts parents/guardians when there is a concern about the camper's health and/or when a situation is not progressing as expected. This may include general illness, injury or an emergency medical situation. Contact is made by phone using the emergency contact information provided by the parent/guardian on the Girl Medical History. Sandy Ridge will attempt to contact parents/guardians first and will then attempt to reach alternate contacts if parents/guardians cannot be reached. If a voice mail system is accessed, a message will be left providing information regarding the child's health and the phone number at camp. Contact will typically be made by the Health Supervisor or Camp Director. However, a staff member, following the directions of the Health Supervisor or Camp Director, may also take this responsibility. All call attempts will be documented on the camper's health card or attached to the health card.

girl scouts of eastern south carolina

Bring to Camp on Check-In Day DO NOT MAIL

Medication Consent Form 2014

Every camper needs to turn in this form. Please remember to bring it with you to Check-In. Do not mail it to any of the Girl Scouts of Eastern South Carolina Service Centers or Camp Properties.

Name_____ Date_____

Camp Session:_____

The following over-the-counter medication will be given as needed if not contraindicated:

1. Acetaminophen or ibuprofen for elevated temperatures, headaches or minor aches and pains.
2. Acetaminophen, ibuprofen, *Midol* or *Pamprin* for menstrual cramps.
3. Antihistamines for runny nose, sneezing or eye irritation due to allergies.
4. Decongestants for nasal congestion.
5. Antitussive/Expectorant for minor cough.
6. Antidiarrheal as needed for diarrhea.
7. Antihistamine, calamine lotion or hydrocortisone may be given for dermatitis and other allergic reactions.
8. Triple antibiotic ointment may be used in open skin areas.

Please check one:

_____ My camper **has** permission to take the above over-the-counter medications.

_____ My camper **does not have** permission to take the above over-the-counter medications.

List all medication (prescription and over-the-counter) brought to camp with camper and explain its purposes:

1._____

2._____

3._____

4._____

5._____

6._____

_____ _____

Parent or Guardian Signature Date

_____ _____

Health Supervisor Signature Date

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CAMPER MEDICAL HISTORY 2014

Name(last)_____ (first) _____Birthdate (Mo/Day/Year) _____ Age _____

Parent or Guardian _____Phone (____)_____

Home Address (street & number) _____City_ _____Zip _____

Business Phone Number (____)_____ Mobile Phone Number(____)_____

In case of emergency, notify (Parent will be called first; please provide contacts other than parent):

1. Name _____Phone (____) _____

   Address (street & number) _____ City _____Zip _____

2. Name _____Phone (____) _____

   Address (street & number) _____ City _____Zip _____

HEALTH HISTORY: (Provide approximate dates where appropriate.)

	Allergies	**Diseases**
Frequent Ear Infections _____	Hay Fever_____	Chicken Pox_____
Heart Defect Disease _____	Ivy Poisoning _____	Measles _____
Convulsions _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Bleeding or clotting disorders _____	Other Drugs _____	Asthma _____

Has girl begun menstruation? (Y) _____ (N) _____ Does the girl have a history of bedwetting? (Y) _____ (N) _____

Is girl currently on medication? (Y) _____ (N) _____

Operations or serious injuries (dates) _____

Chronic or recurring illness (dates) _____

Other diseases or details of above: _____

Name of family physician: _____ Phone (____) _____

(if other than examining physician)

Any specific activities to be encouraged/restricted? _____

IMPORTANT: Please notify us if any Girl Scout has been recently exposed to any communicable disease during the three (3) weeks prior to camp attendance.

GIRL SCOUTS OF EASTERN SOUTH CAROLINA COUNCIL

AUTHORIZATION TO TREAT MINOR

I/We, the undersigned, am either a custodial parent or guardian of _____, a minor (the "**Minor**"), and do hereby authorize the adult leaders and agents of the Girl Scouts of Eastern South Carolina (collectively the "**Authorized Persons**") to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care for the Minor under the general or special supervision and upon the advice of or to be rendered by a licensed physician, and to consent to any X-ray, examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care for the Minor by a licensed dentist. Each of the authorized persons may exercise the authority granted hereby individually and without the knowledge, consent or joint action of any other of the authorized persons. It is understood that an effort shall be made to contact the parent or guardian prior to rendering treatment to the Minor, but that any of the above treatments will not be withheld if the parent or guardian cannot be reached.

AUTHORIZATION TO ATTEND CAMP

I/We give permission for _____to participate in all camp activities, with the exception of those restrictions indicated on the reverse side.

AUTHORIZATION TO TRANSPORT MINOR

I/We hereby give permission for _____ to ride in a vehicle driven by a licensed adult driver, or, in an emergency, a minor licensed driver, in a vehicle which has at least minimum liability insurance as required by the State of South Carolina, for Girl Scout camp activities.

Signature _____ Date _____

IMMUNIZATION HISTORY: Record the month and year of basic immunization and the most recent boosters.
You can also attach a copy of shot record received from physician/health department/DHEC.

Vaccines:	**Dates of immunizations**
Diptheria Pertussis (Whooping Cough)DPT* Tetanus Or	1. 4. 2. 5. 3.
Tetanus TD* Diphtheria	1. 4. 2. 3.
Polio	
Measles, Mumps, Rubella	1. 2.
Haemophilus influenzae “b” (HBCV)	1. 3. 2. 4.
Hepatitis B	1. 2. 3.
Varicella Vaccine (Chicken Pox)	1.

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ADULT MEDICAL HISTORY 2014

Name(last)_____ (first) _____Birthdate (Mo/Day/Year) _____ Age _____

Parent or Guardian _____Phone (____)_____

Home Address (street & number) _____City_ _____Zip _____

Business Phone Number (____)_____ Mobile Phone Number(____)_____

In case of emergency, notify:

1. Name _____Phone (____) _____

Address (street & number) _____ City _____Zip _____

HEALTH HISTORY: (Provide approximate dates where appropriate.)

	Allergies	**Diseases**
Frequent Ear Infections _____	Hay Fever_____	Chicken Pox_____
Heart Defect Disease _____	Ivy Poisoning _____	Measles _____
Convulsions _____	Insect Stings _____	German Measles _____
Diabetes _____	Penicillin _____	Mumps _____
Bleeding or clotting disorders _____	Other Drugs _____	Asthma _____

Operations or serious injuries (dates) _____

Chronic or recurring illness (dates) _____

Other diseases or details of above: _____

Name of family physician: _____ Phone (____) _____
(if other than examining physician)

Any specific activities to be encouraged/restricted? _____

My personal health insurance is (Company)_____ (Policy No.)_____

IMPORTANT: Please notify us if you have been recently exposed to any communicable disease during the three (3) weeks prior to camp attendance.

GIRL SCOUTS OF EASTERN SOUTH CAROLINA COUNCIL

Emergency Care Authorization

In the event of an emergency which renders me unconscious or unable to give my consent for emergency medical treatment, I hereby give my permission and consent to any medical or surgical diagnosis or treatment or hospital care deemed advisable by or administered by a licensed physician. This authorization is given with the knowledge that in no event will the Girl Scouts of Eastern South Carolina, its officers, leaders or agents be held liable for any first aid or surgical treatment or procedures performed pursuant to this consent.

Signature _____ Date _____