

# Summary Form

## To be completed by Parent or Troop Leader

If a camper is attending day camp with her troop then the TROOP LEADER will be responsible for collecting all the forms listed below for each day camp participant and submitting that paperwork as a troop along with a Troop Registration Roster and one troop check by the deadline.

Parent or Leader's Name \_\_\_\_\_ Troop # \_\_\_\_\_

E-mail \_\_\_\_\_ Phone # \_\_\_\_\_

There will need to be one set of forms collected for every camper/participant registered for the day camp. Please review all forms to make sure they are completed and signed prior to the registration deadline. The day camp will contact the parent/Troop Leader if there is any missing information. Please submit one troop account check with two signatures or use personal check if registering your individual camper.

Registration is due to the Day Camp Registrar by **May 7, 2018**.

If you have any questions, please contact a Day Camp Director:

Cindy Bethancourt, [wahagi@aol.com](mailto:wahagi@aol.com) or Jeanne Smith, [froberg@ix.netcom.com](mailto:froberg@ix.netcom.com).

### Checklist

- ☐ Registration for each participant **COMPLETED ONLINE**
- ☐ Health History form for each participant **COMPLETED & SIGNED**
- ☐ Waiver of Liability for each Camper, Camp Aide, Adult Volunteer, Pixie or Boy, **COMPLETED & SIGNED**
- ☐ Photo Release - required if someone other than parent/guardian completed on-line registration (to be emailed to you)
- ☐ Medication Release Form **As Needed** (to be emailed to you)
- ☐ Appropriate fees from each Camper/Family collected and **TURNED INTO DAY CAMP**

(Individual registration payment instructions listed below)

| <b>Fees:</b>   | <b>Quantity</b> | <b>Amount</b> |
|--|-----------------|---------------|
| Girl Scout Camper - \$55 (\$70 after May 7, 2018 if space available) | _____           | _____         |
| Girl Scout Camper Aide (GEM) - \$35                                  | _____           | _____         |
| Girl Scout Adult Volunteer for 2 to 5 days – No fee                  | _____           | _____         |
| Girl Scout Adult Volunteer for 1 day – \$10 T-shirt fee              | _____           | _____         |
| Pixie (Pre-K) Camper - \$10 T-shirt fee                              | _____           | _____         |
| Boy Camper - \$10 T-shirt fee  | _____           | _____         |
| <b>TOTAL COST =</b>  |                 | _____         |

If registering individual camper, please make check payable to “*Fullerton La Habra Day Camp*” and send to:

Araceli Sosa, 1641 Brookdale Ave., La Habra, CA 90631

If participant(s) attending day camp with troop, make check payable to troop and submit to troop leader.

No refunds after May 20, 2018.

## Camper Name

First

Middle

Lars

Day Camp

Day Camp Location

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# Camper Health History

Camper Name: \_\_\_\_\_

First

Middle

Last

Birth Date: \_\_\_\_\_

Month/Day/Year

**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 | 11. Had fainting or dizziness? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? .....                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? .....                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? .....               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?.....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? .....                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. 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 | 15. Have problems with falling asleep/sleepwalking? .....                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?.....         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? .....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? .....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?.....                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Has frequent headaches?.....                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eye-wear?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?.....                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Currently taking medication?.....                    | Yes No   | For travel outside the country, please name countries visited and dates of travel. |  |

If yes, please fill out the medication form

**Please explain ALL "Yes" answers in the space below, noting the number of the questions.**

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

Has the camper:

- |  |  |
|--|--|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

***Please explain "Yes" answers in the space below, and indicate the number of the question. The day camp staff may contact you for additional information.***

**My child is NOT taking any medication.**

**My child is taking medication and/or may need  
Over-the-Counter (OTC) medication at Day Camp.  
(form will be email to you)**



## Day Camp Adult Volunteer Health History

|   |      |                  |          |
|---|------|------------------|----------|
| Name: _____   |      | Camp Name: _____ |          |
| First   | Last |                  |          |
| Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male   |      | Birthdate: _____ |          |
| Address: _____  |      |                  |          |
| Street Address  | City | State/ /Country  | Zip Code |
| E-mail: _____   |      |                  |          |
| Is this your first year as Day Camp Staff? . . . . . <input type="checkbox"/> No <input type="checkbox"/> Yes |      |                  |          |

**Chronic Concerns:** Check all that pertain to you and provide information about supportive healthcare.

\_\_\_\_\_ I have no chronic health concerns.

\_\_\_\_\_ I have the following chronic health concern(s):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Headaches, Migraines   | <input type="checkbox"/> Sleep problem     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Difficulty breathing   | <input type="checkbox"/> Dysmenorrhea      |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> Surgical history       | <input type="checkbox"/> Seizure disorder: |
| <input type="checkbox"/> Back pain or injury | <input type="checkbox"/> Knee or ankle weakness | <input type="checkbox"/> Other: _____      |

**General Physical History:** If you answer "Yes" to any of these questions, provide more information at the end of this section.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Have you ever been hospitalized? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever passed out during or after extensive physical activity? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever been dizzy during or after extensive physical activity? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you ever had chest pain during or after extensive physical activity? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you tire more quickly than others during physical activity? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you ever had high blood pressure? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you ever had a racing heartbeat or skipped heartbeats? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you ever been knocked out or become unconscious? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Do you have skin problems (itching, rash, acne)? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Have you ever had a seizure? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Have you ever had a stinger, burner, or pinched nerve? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Have you ever had heat or muscle cramps? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Have you ever been dizzy or passed out in the heat? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Have you had mononucleosis in the past nine months? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Do you wear glasses, contacts or use protective eye wear? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Do you smoke and/or use other tobacco products? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Do you use e-cigarettes? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Do you have any dental issues/orthodontics (braces, retainers)? . . . . .   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. For women: do you have any menstrual problems (pain, irregularity etc) . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Do you have any allergies? This includes food, medication, bees, environmental, animals.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Have you ever sprained, strained, dislocated, fractured, broken or had repeated swelling, or other injuries to any of your body areas? . . . . .                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, where? <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Leg <input type="checkbox"/> Neck <input type="checkbox"/> Chest |                              |                             |
| <input type="checkbox"/> Arm, hand <input type="checkbox"/> Ankle <input type="checkbox"/> Back <input type="checkbox"/> Hip <input type="checkbox"/> Foot              |                              |                             |
| 22. Have you been in countries other than the United States in the past nine months? . . . . .  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, list the countries and the time spent in them.

Country: \_\_\_\_\_ Dates: \_\_\_\_\_

Country: \_\_\_\_\_ Dates: \_\_\_\_\_

Country: \_\_\_\_\_ Dates: \_\_\_\_\_



## Day Camp Adult Volunteer Health History

Please use the space below to explain and/or provide more detail about the General Physical Health questions to which you responded "Yes."  
Please use another piece of paper as needed.

# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_

### Mental & Emotional Health Information:

- A. Have you been diagnosed with attention deficit disorder (ADD or AD/HD)?
- B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that may impact your ability to work?
- C. Do you have an eating disorder?
- D. Do you have a learning disability?
- E. Do you have an emotional health concern that may impact your ability to do your job?
- F. During the past year have you seen a professional about any emotional/mental concerns that could impact your work?

If "yes" to any of the questions in this section, please attach a statement that:

- A. Describes the concern and your management plan for addressing it while working at camp; and
- B. Describes the support needed for your immediate supervisor and camp director

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Insurance Company Phone Number \_\_\_\_\_

### Emergency Contact: *Who do you want us to contact in an emergency?*

First Contact: \_\_\_\_\_ Preferred Phone: (\_\_\_\_\_) \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Preferred Phone: (\_\_\_\_\_) \_\_\_\_\_ Relationship to You: \_\_\_\_\_

### Authorization for Disclosure of Healthcare:

I verify that this health history is correct. That I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand that my health information will be used by the Day Camp's Health Staff in providing care to me and can be shared with and or viewed by the Day Camp Director.

Signature of  
Day Camp Volunteer: \_\_\_\_\_ Date: \_\_\_\_\_

### AUTHORIZATION TO CONSENT TO TREAT

(I) do hereby authorize the Girl Scout Council of Orange County as Agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital or at health center of camp by Registered Nurse and or designated First Aider.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid Agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, in the exercise of her/his best judgment, may deem advisable.

I also understand that the Girl Scout Accident/Sickness Insurance for GSOC Day Camp is secondary coverage. This means that the Girl Scout Insurance pays only the portion your family medical insurance does not pay, subject to limits set forth in the Accident/Sickness policy for GSOC Day Camp. If you do **not** have family medical insurance, our insurance company will require that you sign a statement to that effect. This authorization shall remain in effect while the staff is in attendance of GSOC Day Camp or camp activities.

Day Camp Volunteer Signature \_\_\_\_\_ Date \_\_\_\_\_

## GIRL SCOUTS OF ORANGE COUNTY

### DAY CAMP RELEASE, WAIVER OF LIABILITY AND INDEMNITY AGREEMENT

I (we), the undersigned parent, parents, or legal guardian of \_\_\_\_\_, a minor, hereby request that she be permitted to attend the Girl Scouts of Orange County's Day Camps ("Camp") from \_\_\_\_\_ to \_\_\_\_\_, and consent to my child's participation in all activities associated with attendance at Camp, including off-site activities (collectively "Camp Activities").

I am aware that while attending Camp, my child may engage in physical activities which may create a risk of harm to my child. I further understand that because of the nature of Camp, my child will not be constantly supervised, therefore potentially giving rise to certain unforeseen circumstances. These risks, in addition to all other possible risks, could result in injury and/or death, and my child and I fully understand the risks and the potential harm that can be associated with participating in Camp and the various Camp Activities. In consideration of my child being permitted to attend Camp and participate in Camp Activities, I hereby:

1. Agree to indemnify and save and hold the Girl Scouts of Orange County, their directors, officers, employees and agents (collectively "GSOC") harmless from any liability, loss, damage, or cost that may occur or be incurred due to the participation of my child in Camp, including all Camp Activities and travel to and from Camp;
2. Release, waive, discharge and covenant not to sue GSOC from all liability to me, my child, her personal representatives, assigns, heirs and next of kin for any loss or damages, and any claim or demands on account of injury to or resulting in death of my child, whether caused by the negligence of GSOC or of any other person while my child is at Camp, engaged in Camp Activities, or traveling to or from Camp;
3. Assume full responsibility for and risk of bodily injury or death, whether due to the negligence of the GSOC or otherwise, while attending Day Camp, engaged in Day Camp Activities, or traveling to or from Day Camp. I expressly acknowledge and understand that accidents and injuries may occur while at Day Camp and expressly assume all of the risks due to the negligence of GSOC and any others participating or contributing to Day Camp;
4. Expressly agree, permit and assume the risk of any medical treatment which may be rendered and agree to expressly release and indemnify GSOC from any liability for providing, or failing to provide, any emergency medical treatment. Furthermore, notwithstanding any medical condition the nature of which I have disclosed to the GSOC, I consent to allow my child to attend Camp. Furthermore, I expressly agree to assume the risks of any medical treatment which may be rendered, or failed to be rendered, with respect to such medical condition, by the GSOC and any other party contributing to operation of Camp.

I further expressly agree that the foregoing release, waiver, and indemnity agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I have read, fully understood its content and voluntarily sign this release, waiver, and indemnity agreement. I further agree that no oral representations, statements, or inducement apart from the foregoing written agreement have been made.

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Signature of Parent or Guardian

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Date