

Name of Event: _____ Date _____

HEALTH HISTORY FORM FOR GIRLS AND ADULTS

This form is carried on outings. Please fill out completely. This information will be used by a health care provider when medical care is needed. This form must accompany all individual event registration forms. *(This form is to be filled out by parents/guardians of minors or by adult members themselves.)*

Participant's Name _____ Name used _____
Last First Initial

Parent/Guardian (or spouse if adult) _____

Address _____ Home Phone () _____
Street & Number City State Zip Area Number

Business Phone (Mother) () _____ Cell Phone () _____ Pager () _____

Business Phone (Father) () _____ Cell Phone () _____ Pager () _____

Troop # _____ Grade Level in fall: Daisy Br. Jr Cad. Sen. Amb Non-Girl Scout

Age _____ Birth date: (Month, day & year) _____

(Check any or all that apply) Asian Black Hispanic White American Indian

Local Emergency Contact (other than parents): Name _____

Address _____ Home Phone () _____
Street & Number City State Zip Area Number

Cell Phone () _____ Business Phone () _____ Relation to participant _____

Name of dentist/orthodontist _____ Phone () _____

Name of family physician _____ Phone () _____

Do you carry family medical/hospital insurance? Yes No

If so, indicate: Carrier _____ Policy or Group # _____

Name of person with insurance _____

All medications:

- Must have parent permission, signed and dated, with specific dosage instructions.
- Must be in original container and prescribed for the participant listed here. Girls may keep asthma sprays, epi-pens, insect repellent, sunscreen, or chapstick with them if they know how to use them.
- Must be turned in to Adult First-Aider.

If participants must keep any medications with them, notify Adult First-Aider in writing.

Current prescription medications _____

Current over-the-counter medications *(send with instructions)* _____

Recommendations and Restrictions

Any treatment to be continued _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional health information _____

Chronic or recurring illness or medical condition _____

Immunization History

 DPT

Emergency Medical Information and Health History

Has, has had, or is subject to: (*Check and give details*)

Allergies: Foods, medicines, insects, plants, pollen, animals. Explain: _____

Any other condition that may require special care, medication, or diet.

Explain _____

Date of last physical _____

Any complicating medical problems noted in last health examination?

Explain _____

For Female:

Has this person menstruated? Yes No If not, has she been told about it? Yes No

If so, is her menstrual history normal? Yes No Special consideration: _____

Important - This box must be completed for participation.

This health history is correct so far as I know, and the person herein described has permission to engage in all Girl Scout program activities except as noted.

Authorization for Treatment: I hereby give permission to the medical personnel selected by the Girl Scout adult in charge to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child/me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Girl Scout adult in charge to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for use off-site.

I also understand and agree to abide with the restrictions placed on my Girl Scout program activities, as noted on this form.

Signature of parent or legal guardian of minor or adult participant

/_____
/Date

Witness

/_____
/Date

Photo Release: I agree that pictures or videos of my daughter may be used to promote the Girl Scout program.

Yes No