girl scouts of southern alabama

Girl Health History Form

Contact Information

Girl Name ______________________________ D.O.B.__________ Troop# __________ S.U. __________

Address ______________________________ City/State/Zip ______________________________

Home Phone # ____

Mother's Name ____________________ Work # ____________________ Cell# ____________________

Father's Name ____________________ Work # ____________________ Cell# ____________________

Emergency Contact (not parent/guardian)

Name ____________________ Phone # ____________________ Relationship ____________________

Medical Information

Physician ______________________________ Phone# ____________________

Medical Insurance ____________________ Subscriber ____________________ Policy/Group# ____________________

If Military Dependent, give location and I.D. number of child's medical records ____________________

General Information:	yes	no	Allergies:	yes	no	Special Needs:	yes	no
Frequent headaches	☐	☐	Hay Fever	☐	☐	Disability	☐	☐
Corrective eye wear	☐	☐	Poison Oak, etc.	☐	☐	Hearing Impairment	☐	☐
Diabetes	☐	☐	Insect Stings	☐	☐	Visual Impairment	☐	☐
Sleepwalking	☐	☐	Asthma	☐	☐	Physical Impairment	☐	☐
Nosebleeds	☐	☐	Animals	☐	☐	Special Dietary Needs	☐	☐
Motion Sickness	☐	☐	Food	☐	☐	Other Special Needs	☐	☐
Convulsions	☐	☐	Drugs	☐	☐			
Kidney	☐	☐	Other	☐	☐			
Heart	☐	☐						
Fainting	☐	☐						
Epilepsy	☐	☐						

If you checked yes to any of the boxes, please explain: ______________________________

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Date of last Tetanus shot: ____________________ Date of last TB skin test: ____________________

List any restrictions or special instructions: ______________________________

List current medications (including over-the-counter): ______________________________

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All medications must be in their original container, accompanied by written instructions from the parent or physician, and given to the troop leader.

This health history is complete and accurate. If circumstances change, I will notify the leader immediately. *The health of the girl is primarily the responsibility of her parents or guardians. The Girl Scout organization strongly recommends annual health examinations, dental check-ups, and immunizations against preventable diseases.*

SIGNATURE of Parent/Guardian ______________________________ Date ____________________

Girl Health History Form continued

Medical Release

To Whom It May Concern:

I, the undersigned parent, or legal guardian of, ________________________________a minor, do hereby consent to any surgical or medical treatment or procedures which may be suggested, recommended, prescribed, or directed by a duly licensed physician in their competent medical judgment as reasonably necessary for my minor child and where any delay in treatment of my child could reasonably be expected to jeopardize the life or health or could reasonably result in disfigurement or impairment to faculties or if the delay would cause undue psychological or emotional distress to my child.

It is understood that this authorization is given in advance of any specific need for its use by a physician who in the exercise of his best medical judgment may deem it advisable to proceed in treating my child. It is understood that every effort shall be made to contact the undersigned prior to treatment, but the undersigned specifically directs that treatment not be withheld if the undersigned cannot be reached.

I further authorize GIRL SCOUTS OF SOUTHERN ALABAMA, INC. or its designee to sign any form required by law evidencing my consent.

My child has permission to engage in all activities, except as noted by me.

List any restrictions____

This consent shall remain effective from ______________________________ to _________________________________

(MM/DD/YY) (MM/DD/YY)

NOTE TO MEDICAL AUTHORITY: As a member of Girl Scouts of the USA, this person is covered by a secondary accident insurance with Mutual of Omaha.

Signature of Parent/Guardian ____Date ________________________