

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

Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Corrective eye wear	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>

Allergies:

yes no

Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Poison Oak, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Animals	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Special Needs:

yes no

Disability	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>
Other Special Needs	<input type="checkbox"/>	<input type="checkbox"/>

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

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

List any restrictions or special instructions: _____

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

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 _____