

GIRL HEALTH HISTORY

➔ **To be completed by parent/guardian.**

➔ This form should provide current information for troop/group meetings, including troop/group trips of less than three (3) nights, and for events.

Give completed form to Troop/Group Leader or Event Facilitator/Coordinator.
For trips three nights or more, also complete the Girl Health Record Form #5121.

Participant Information			
Name (Last, First, Initial)	Parent/Guardian	Birth Date	Age
Address	City	ST	Zip
Home Phone	Work Phone	Cell Phone	
In Emergency Notify (Secondary Contact)	Address	Relationship to Girl	
Home Phone	Work Phone	Cell Phone	
Insurance Information (Optional) This information may be released, if necessary, for insurance purposes.			
Carrier	ID Number	Group Number	
Member Services Phone Number	Address	<i>I accept full responsibility for the costs of any medical care/treatment I have hereby authorized.</i>	
Licensed Physician's Name and Phone Number		Name	Phone Number
A. Health History (Check all that apply.)			
Diseases	Allergies	Chronic or Recurring Illness	
<input type="checkbox"/> Kidney <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Lyme <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Mumps <input type="checkbox"/> German Measles <input type="checkbox"/> Measles <input type="checkbox"/> Other _____ <input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Animals <input type="checkbox"/> Plants <input type="checkbox"/> Food <input type="checkbox"/> Pollen <input type="checkbox"/> Hay Fever <input type="checkbox"/> Medicine/Drugs <input type="checkbox"/> Insect Stings* *If yes, antidote must be provided. <input type="checkbox"/> Other _____	<input type="checkbox"/> Seizures <input type="checkbox"/> Ear Infections <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Sinusitis <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Hypertension <input type="checkbox"/> Other _____	
Impairments: <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Sight <input type="checkbox"/> Physical _____ <input type="checkbox"/> Other _____		<input type="checkbox"/> Tetanus Shot _____ Last Booster Date	
My Girl Scout has permission to take or use the following over-the-counter medications if provided by me in their original container with a signed Permission to Give Over-the-Counter Medication form.			
<input type="checkbox"/> Acetaminophen (i.e. Tylenol) <input type="checkbox"/> Ibuprofen (i.e. Advil) <input type="checkbox"/> Antacids (i.e. Tums) <input type="checkbox"/> Calamine lotion (i.e. Caladryl)	<input type="checkbox"/> Antibiotic Ointment (i.e. Bacitracin/Bactoban) <input type="checkbox"/> Wound Wash and/or Hydrogen Peroxide <input type="checkbox"/> Antihistamine (i.e. Benadryl/Sudafed) <input type="checkbox"/> Antidiarrhea (i.e. Pepto-Bismol)	<input type="checkbox"/> Hydrocortisone Cream <input type="checkbox"/> Expectorant (i.e. Robitussin) <input type="checkbox"/> Alcohol-Vinegar Solution(i.e. Swimmer's Ear)	
Does participant carry an Epi-pen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Participant may self-administer <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does participant carry an Inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No		Participant may self-administer <input type="checkbox"/> Yes <input type="checkbox"/> No	
Restrictions (The following restrictions apply to this individual.)			
Does not eat: <input type="checkbox"/> Red meat <input type="checkbox"/> Pork <input type="checkbox"/> Poultry <input type="checkbox"/> Seafood <input type="checkbox"/> Dairy products <input type="checkbox"/> Eggs <input type="checkbox"/> Peanuts <input type="checkbox"/> Wheat <input type="checkbox"/> Gluten <input type="checkbox"/> Other			
Explain any restrictions to food or activity (e.g., what cannot be done, what adaptations or limitations are necessary). Attach explanation if needed.			
General Questions (Explain "yes" answers below.)			
Has/does the participant:		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Ever passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have frequent nosebleeds?			
8. Have a history of bedwetting?			
9. Have any skin problems (e.g., itching, rash)?			
10. Have problems with diarrhea/constipation?			
11. Have severe menstrual cramps?			
12. Have an orthodontic appliance being brought to activity?			
Please explain any "yes" answers, noting the number of the questions. Attach additional explanations, if needed.			
Health Information Privacy Statement and Permission to Treat			
The Girl Health History is for health care concerns. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event, Event Coordinator, or the Troop/Group Leader. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. I have read the above procedures for handling the health form information, and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.			
<i>This health history is complete and accurate. My Girl Scout has permission to engage in all prescribed activities, except as noted by me. I hereby authorize troop/group adults and/or Event Coordinators to give necessary First Aid/CPR to my Girl Scout and authorize the person in charge to obtain and consent, on my behalf, to whatever medical diagnosis treatment is deemed necessary or advisable for the well-being of my Girl Scout. I also authorize troop/group adults and/or Event Coordinators to transport my Girl Scout in case of emergency.</i>			
*Signature of Parent/Guardian		Date 1 st year:	
I have reviewed my Girl Scouts' above health information and verify that all information is complete and accurate.			
*Signature of Parent/Guardian		Date 2 nd year:	
*Original signature is required			