girl scouts of connecticut

GIRL SCOUTS OF CONNECTICUT

www.gsofct.org 1-800-922-2770

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 accept full responsibility for the costs of any medical care/treatment I have hereby authorized.*

Licensed Physician's Name and Phone Number	**Name**	**Phone Number**

A. Health History (Check all that apply.)

Diseases		**Allergies**		**Chronic or Recurring Illness**	
☐Kidney	☐Chicken Pox	☐Animals	☐Plants	☐Seizures	☐Ear Infections
☐Lyme	☐Rheumatic Fever	☐Food	☐Pollen	☐Asthma	☐Heart Defect/Disease
☐Mumps	☐German Measles	☐Hay Fever	☐Medicine/Drugs	☐Arthritis	☐Bleeding Disorders
☐Measles	☐Other	☐Insect Stings*	_____	☐Sinusitis	☐Musculoskeletal Disorders
☐Tuberculosis	_____	* If yes, antidote must be provided.	☐Other _____	☐Diabetes	☐Frequent Headaches
				☐Hypertension	☐Other _____

Impairments: ☐Speech ☐Hearing ☐Sight ☐Physical _____ ☐Other _____

☐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.

☐ Acetaminophen (i.e. Tylenol)	☐Antibiotic Ointment (i.e. Bacitracin/Bactoban)	☐Hydrocortisone Cream
☐Ibuprofen (i.e. Advil)	☐Wound Wash and/or Hydrogen Peroxide	☐ Expectorant (i.e. Robitussin)
☐Antacids (i.e. Tums)	☐ Antihistamine (i.e. Benadryl/Sudafed)	☐ Alcohol-Vinegar Solution(i.e. Swimmer's Ear)
☐Calamine lotion (i.e. Caladryl)	☐Antidiarrhea (i.e. Pepto-Bismol)	

Does participant carry an Epi-pen? ☐Yes ☐No **Participant may self-administer** ☐Yes ☐No

Does participant carry an Inhaler? ☐Yes ☐No **Participant may self-administer** ☐Yes ☐No

Restrictions (The following restrictions apply to this individual.)

Does not eat: ☐Red meat ☐Pork ☐Poultry ☐Seafood ☐Dairy products ☐Eggs ☐Peanuts ☐Wheat ☐Gluten ☐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		Yes	No
1. Had any recent injury, illness, or infectious disease?	☐	☐	7. Have frequent nosebleeds?	☐	☐
2. Ever had a head injury?	☐	☐	8. Have a history of bedwetting?	☐	☐
3. Wear glasses, contacts, or protective eye wear?	☐	☐	9. Have any skin problems (e.g., itching, rash)?	☐	☐
4. Ever passed out during exercise?	☐	☐	10. Have problems with diarrhea/constipation?	☐	☐
5. Have problems with sleepwalking?	☐	☐	11. Have severe menstrual cramps?	☐	☐
6. Ever had emotional difficulties for which professional help was sought?	☐	☐	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.

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.

*Signature of Parent/Guardian Date 1st year:

I have reviewed my Girl Scouts' above health information and verify that all information is complete and accurate.

*Signature of Parent/Guardian Date 2nd year:

Original signature is required