**Girl Health History and Emergency Medical Authorization Form** This form must be completed annually and as changes occur by the child’s parent or guardian and returned to the troop leader and/or troop first-aider prior to attending the first troop meeting. Use additional paper if needed.

Child’s Name: Address: City: State: Zip:

Date of Birth: Age: School: Grade: Troop Number:

# PARENT/GUARDIAN INFORMATION

Child is in the custodial care of: Both Parents Mother Only Father Only Other:

**Parent/Guardian 1:** Address (if different than child’s):

Phone 1: Phone 2: Phone 3: E-mail:

**Parent/Guardian 2:** Address (if different than child’s):

Phone 1: Phone 2: Phone 3: E-mail:

# EMERGENCY CONTACTS

Name: Relationship: Phone 1: Phone 2: Phone 3:

Name: Relationship: Phone 1: Phone 2: Phone 3:

**HEALTH INFORMATION** (Check all that apply and provide requested information)

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergies** | **Yes** | **No** | **Explain “yes” answers. Include the type of allergy (e.g.- “nut allergy” in the food category)** |
| **Animals** |  |  |  |
| **Insect Stings** |  |  |  |
| **Plants/Trees** |  |  |  |
| **Food** |  |  |  |
| **Drugs** |  |  |  |
| **Other** |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Condition** | **Dates** |  | **Condition** | **Dates** |  | **Condition** | **Dates** |
|  | ADD/ADHD |  |  | Epilepsy |  |  | Muscle Disease/Disorder |  |
|  | Arthritis |  |  | Fainting |  |  | Nervous System Disorder |  |
|  | Asthma |  |  | German Measles |  |  | Sickle Cell Anemia |  |
|  | Athletes Foot |  |  | Hay Fever |  |  | Sinusitis |  |
|  | Bed Wetting |  |  | Headaches/Migraines |  |  | Skeletal Disease/Disorder |  |
|  | Bleeding/Clotting Disorder |  |  | Hearing |  |  | Skin Conditions |  |
|  | Bronchitis |  |  | Heart Defect/Disease |  |  | Sleep Disturbance/Walking |  |
|  | Chicken Pox |  |  | Hypertension |  |  | Stomach Upsets |  |
|  | Colds/Sore Throats |  |  | Kidney Disease |  |  | Urinary Tract Infections |  |
|  | Constipation |  |  | Measles |  |  | Wear: Contacts Glasses |  |
|  | Convulsions |  |  | Mononucleosis |  |  | Other:  |  |
|  | Diabetes |  |  | Motion Sickness |  |  | Other:  |  |
|  | Ear Infections |  |  | Mumps |  |  | Other:  |  |

Explain any specific needs or accommodations required:

Explain any known behavioral and/or emotional problems:

Explain any psychiatric counseling or hospitalization:

Explain any operations or serious injuries:

Explain any disabilities or chronic or recurring illnesses:

Explain any activities that are discouraged or limited by your child’s physician:

Explain any dietary modifications:

Has menstruation begun? Yes No If not, does she know what it is? Yes No If yes, is her menstrual history normal? Yes No

|  |  |  |  |
| --- | --- | --- | --- |
| **Since her last health exam, has your child had:** | **Yes** | **No** | **Explain “yes” answers. Provide details and dates.** |
| **A serious injury requiring medical attention?** |  |  |  |
| **An illness lasting longer than one week?** |  |  |  |
| **An in-patient hospital or emergency room treatment?** |  |  |  |
| **Restrictions from participating in any activities?** |  |  |  |

Date of Last Health Exam: Current Height: Current Weight:

# IMMUNIZATION HISTORY

Are all immunizations current? Yes No If not, state reason(s): DTP or DT (Tetanus) Date:

# MEDICATION INFORMATION

Are any prescription medications being taken? Yes No Are any of the following used? Inhaler EpiPen

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Reason for Medication** | **Dosage** | **Frequency** |
|  |  |  |  |
|  |  |  |  |

My child may be given: Aspirin Benadryl Ibuprofen Neosporin Tylenol None

# MEDICAL CARE AND INSURANCE INFORMATION

Physician: Phone: Dentist/Orthodontist: Phone:

Preferred Medical Facility: Address:

Insurance Company: Policy #: Policy Holder:

Company Address: City: State: Zip:

**AUTHORIZATION FOR MEDICAL CARE**

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I

hereby give permission to the First-Aider or Adult-In-Charge to provide routine health care and witness prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child’s participation in any activity sponsored by Girl Scouts of the USA, Girl Scouts Nation’s Capital, or individual units. Should a medical emergency arise during my child’s participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child’s life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Signature:

Date:

\* If for any reason you cannot sign this form, attach a written statement to this form. The statement must be signed for attendance/participation.