girl scouts of greater south texas

Confidential Girl HealthHistory

This form must be completed and signed by parents/guardians of girls or by adult members themselves. All health history forms will be held in limited access by the trustee (leader/facilitator/staff) of the specific Girl Scout program. The absolute minimal necessary information may be shared with program staff/volunteers in order to provide adequate care. The health history form will be retained by the Girl Scout program trustee until it is destroyed. This form must be signed. Duplicate this form as needed.

SECTION A: MEMBER INFORMATION

Name_____ Date of Birth_____ Age Troop # _____
Address_____ City, ZIP _____
Parent/Guardian_____ Phone (_____) _____
Home Address_____ City, ZIP _____
Business Phone (_____)_____ Home Phone (_____) _____
If Parent/Guardian is unavailable, contact:_____ Relationship: _____
Address_____ Phone (_____) _____
Name of Family Physician:_____ Phone (_____) _____
Insurance Carrier:_____ ID Number _____
Insurance Carrier's Contact Phone Number (_____) _____

SECTION B: HEALTH HISTORY / RECURRING CONDITIONS / MEDICATION PERMISSIONS

Check each applicable item, giving appropriate dates and comments.

ALLERGIES / DESCRIPTION
- ☐ Foods _____
- ☐ Insects _____
- ☐ Plants _____
- ☐ Drugs _____
- ☐ Animals _____
- ☐ Hay fever _____
- ☐ Asthma _____
- ☐ Latex _____
- ☐ Other _____

ADDITIONAL INFORMATION
- ☐ Operation/Date _____
- ☐ Serious Injury/Date _____
- ☐ Sleepwalking
- ☐ Bedwetting
- ☐ Fainting
- ☐ Constipation
- ☐ Night Disturbances

RECURRING CONDITIONS
- ☐ Ear Infections
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Convulsions
- ☐ Bronchitis
- ☐ Frequent Colds
- ☐ Frequent Sore Throat
- ☐ Stomach Upset
- ☐ Diabetes
- ☐ Hyperactivity
- ☐ Epilepsy
- ☐ Hearing Impairment
- ☐ Vision Impairment
- ☐ Orthopedic Impairment
- ☐ Learning Disability
- ☐ Other _____

DISEASES / DATES
- ☐ Chicken Pox _____
- ☐ Measles _____
- ☐ German Measles _____
- ☐ Mumps _____
- ☐ Scarlet Fever _____
- ☐ Rheumatic Fever _____
- ☐ Poliomyelitis _____
- ☐ Whooping cough _____
- ☐ Other _____

Date of last health examination_____/_____/_____
Were any complicating medical problems noted?
_____
Is participant now under the care of a physician / psychologist? _____
List restrictions to swimming, diving, running, etc. _____

Describe any medical/dietary regimen to be continued:
_____

OVER-THE-COUNTER MEDICATION PERMISSIONS
My daughter/ward has permission to take or use the following upon recommendation by a First Aider:
- ☐ Acetaminophen
- ☐ Ibuprofen
- ☐ Decongestant
- ☐ Antihistamine oral or cream
- ☐ Anti-diarrheal liquid or tablets
- ☐ Antacid tablets
- ☐ Expectorant
- ☐ Alcohol-vinegar solution ear drops
- ☐ Other _____

Since last health examination, has the participant had:
A serious illness requiring medical attention? _____
An illness lasting more than 5 days? _____
A surgical operation or fracture? _____
Treatment in a hospital or emergency room? _____
Any restrictions concerning physical activities? _____
Exposure to a contagious disease?_____ Within the past month?_____ What? _____

SECTION C: PARENT/GUARDIAN MUST COMPLETE THE INFORMATION BELOW

I have read the procedures for handling my daughter/ward's health history information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. In case of emergency, I give permission for the First Aider(s) to administer medication and/or First Aid AND give permission to an attending physician to hospitalize or secure proper treatment/surgery for me/my child. I give permission to transport me/my child to the nearest emergency facility for treatment. I know of no reason(s), other than the information indicated on this form, why I/my child should not participate in prescribed activities except as noted.

Signature of parent/guardian_____ Date _____