girl scouts of greater south texas

Confidential Girl Health History

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
- D Foods _______________
- D Insects _______________
- D Plants _______________
- D Drugs _______________
- D Animals _______________
- D Hay fever _______________
- D Asthma _______________
- D Latex _______________
- D Other _______________

ADDITIONAL INFORMATION
- D Operation/Date __________
- D Serious Injury/Date _______
- D Sleepwalking
- D Bedwetting
- D Fainting
- D Constipation
- D Night Disturbances

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

DISEASES / DATES
- D Chicken Pox ___________
- D Measles ___________
- D German Measles _________
- D Mumps ___________
- D Scarlet Fever ___________
- D Rheumatic Fever _________
- D Poliomyelitis ___________
- D Whooping cough _________
- D 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:

____

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? ____________________

OVER-THE-COUNTER MEDICATION PERMISSIONS

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

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 _________________