Girl Scouts

Girl Health History Record

ALL INFORMATION TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN OF GIRL ANNUALLY

PART I: GIRL RECORD

Girl's Name | School Attending | Birth Date | Troop Number

Address/City/State/Zip | Family E-Mail Address *(For GSNC use only)*

Mother's Name | Day Time Telephone ( ) | Evening Phone ( )

Father's Name | Day Time Telephone ( ) | Evening Phone ( )

Is your girl/ward disabled? ❒ **NO** ❒ **YES** **If YES, does she need accommodation?** ❒ **NO** ❒ **YES**

Do we have your permission for your child/ward to receive emergency medical treatment if needed? ❒ **NO** ❒ **YES**

HEALTH INFORMATION PRIVACY STATEMENT

The Girl Health History Record is for health care concerns at the specified event only. 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. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. *I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.*

Parent/Guardian Signature: **Date:**

I give permission for my daughter to receive treatment for routine medical and/or first aid needs as outlined in the Treatment Protocols and for the administration of prescribed medications. I understand that in the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Northern California to give emergency medical and surgical treatment and hospitalization as necessary for my child and/or dependent minor by a licensed physician pursuant to Section-6910 of the civil Code of California. I know of no reason(s) other than the information indicated on this form, why my daughter/dependent should not participate in prescribed activities.

Parent/Guardian Signature | Date | Telephone Number | Cell Phone Number

PART II: EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN

Name | Day Time Telephone ( ) | Evening Phone ( )

PART III: HEALTH INSURANCE INFORMATION

Name of family DENTIST:_____Telephone: ( )_____

Name of family PHYSICIAN:_____Telephone: ( )_____

Family Medical/Hospital INSURANCE CARRIER: _____POLICY/GROUP NUMBER: _____

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) ❒ **Check here for no known allergies**

❒Animals_____ ❒Hay Fever_____ ❒Medicines/Drugs _____ ❒Pollen _____

❒Food _____ ❒Insect Stings_____ ❒Plants_____ ❒Other (specify) _____

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates) ❒Other Chronic/Recurring Illnesses (specify) _____

❒Asthma _____ ❒Diabetes_____ ❒Heart Defect/Disease_____ ❒Musculoskeletal Disorder _____

❒Bleeding/Clotting Disorders ___ ❒Ear Infection_____ ❒Hypertension _____ ❒Seizures _____

Date of last health examination: _____ Were any complicating medical problems noted in last health examination? ❒NO ❒YES

If YES, what? _____

Other Health Conditions: (Check those that apply) ❒Other (specify): _____

❒Attention Deficit Disorder (ADD) ❒Down's Syndrome ❒Hearing Impairment ❒Nose Bleeds ❒Wears Glasses/Contacts

❒Bed Wetting ❒Emotional Disturbances ❒Menstrual Cramps ❒Sickle Cell Trait/Disease ❒Special Dietary Regimen

❒Dental Braces ❒Fainting ❒Motion Sickness ❒Sleep Disturbances ❒Visual Impairment

PART V: MEDICATION

Is your girl taking any medications? ❒ NO ❒ YES

If YES, list medication, reason, and possible side effects.

MEDICATION	REASON	POSSIBLE SIDE EFFECTS

Activity Restrictions? ❒ NO ❒ YES

If YES, list restrictions.

_____

_____

_____

PART VI: IMMUNIZATION HISTORY

❒ The following is my girl's immunization history:

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P (Diphtheria, tetanus and pertussis (whooping cough))		
Td		
Measles		
Mumps		
Rubella (German measles)		
Polio		
Hbpv		
Tuberculin Test (most recent)	Result:	
Other (Specify):		

❒ **I/We have chosen not to immunize my/our girl.**

Parent/Guardian Signature | Date

Please review this form annually. If there are no changes or just minor adjustments, please mark those, then sign and date the form.

Forms Bank/Health Forms/HH_Girl_Health_History.doc 03/2009

Updated _____ Date _____

Updated _____ Date _____

Updated _____ Date _____