Girl Scout's Health History

Must be completed and signed by Parent/Caregiver

Girl Scout Information

Girl Scout's Name:____

Service Unit #:_________ Troop #:___________Date of Birth:_____/_____/__________ Age:_________

Address:____

Town:______________________________ State:_________ Zip:______________

1. Parent/Caregiver's Name:____

*Address:*____

*Town:*______________________________ *State:*_________ *Zip:*______________

Home Phone:______________________ Cell Phone:______________________

Email:______________________ Name of Employment:______________________

Work Phone:______________ Address:______________________________

Town:______________________________ State:_________ Zip:______________

2. Parent/Caregiver's Name:____

*Address:*____

*Town:*______________________________ *State:*_________ *Zip:*______________

Home Phone:______________________ Cell Phone:______________________

Email:______________________ Name of Employment:______________________

Work Phone:______________ Address:______________________________

Town:______________________________ State:_________ Zip:______________

Emergency Contact (Other Than Parent/Caregiver)

Contact Name:______________________________ Cell Phone:______________

Home Phone:__________________ Relationship to Girl Scout:______________________

Girl Scout's Name:

(Last Updated: 3/22/21)

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General Health Information

Primary Physician:____ Phone:____________________

Health Insurance:________________________________ Policy/Group #:______________________

Check all that apply and give appropriate dates:

	Asthma:		Heart Defect/Disease:
	Bleeding/Clotting Disorders:		Hypoglycemia:
	Diabetes:		Motion Sickness:
	Emotion Disturbances:		Nosebleeds:
	Fainting:		Special Dietary Regimen:
	Hearing Impairment:		
	Other chronic or recurring illnesses/injuries (specify):		

Date of last health examination:______________________

Since last examination, hast Girl Scout had (check all that apply)

	Serious injury requiring medical attention?		An illness lasting more than 5 days?
	Any prescribed medication?		A surgical operation or fracture?
	Treatment in a hospital or emergency room?		Any restrictions concerning physical activities?

Please explain any "yes" answers to the above questions with dates (use additional paper as necessary)

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Disease and Immunization History

Which of the following has the Girl Scout had? Attach physician form or check boxes and list dates.

	See attached physician form		Mumps:
	Measles:		Hepatitis A:
	Chicken Pox:		Hepatitis B:
	German Measles:		Hepatitis C:

Immunization Dates are required. You can attach physician form. ("Up to date" is NOT acceptable)

Vaccine	***Primary Series Dates***	***Last Booster Date***	TB Mantoux Test Date:
DTP			Results: Pos. Neg.
TD (Tetanus/diphtheria)			H1N1 Date:
Chicken Pox			Influenza Date:
Tetan Varicella (Chicken Pox)			
Polio			*Immunization Waiver: Parent/Caregiver must attach the completed exemption form:* **Download Form**
MMR			
Haemophilus Influenza B			
Hepatitis B			

Allergies – Indicate type and describe reaction, emergency allergy action plan, and doctor's documentation:

Health Needs

	Wears contact lenses/corrective glasses		Wears medical ID for:
	Wears orthodontic appliance &/or orthopedic device		Wears an insulin pump
	Seizures – What type:		Helped By:
	Carries Epinephrine Auto-Injector - Physician's note attached: Yes No Parent/Caregiver's Permission attached: Yes No		
	Other:		

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HIPPA Privacy Rule

I authorize the use of information to promote and monitor well-being while in camp, and as necessary, provision of first aid/ emergency care as best as possible, according and not limited to certifications, training, and availability. This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my Girl Scout/I should not participate in Girl Scout activities except as noted.

Emergency Medical Authorization

In the event that there is an emergency, and I cannot be reached, I give permission for the adult in charge to take my Girl Scout, to a qualified licensed physician or to a nearby hospital for necessary treatment.

I understand that in order to dispense medication that this will not occur unless she/he has written authorization and instructions from the child’s doctor to dispense non-prescription and/or prescription medication (including vitamins, nutritional supplements, etc.). All medications must be in their original pharmacy containers, with an intact current prescription label. No exceptions will be made.

Parent/Caregiver’s Signature:____Date:____________________

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