girl scouts
of suffolk county

Girl Health History

This must be completed and signed by the parent/guardian.

Girl Name: ____

Girl Name: ____

Date of Birth: ____________ **Age:** ________ **Service Unit #:** ________ **Troop #:** __________

Address: ______________________________ **City:** ______________ **State:** _____ **Zip:** ________

Mother/Guardian's Name: ________________________ **Is address different than child's?** Yes No

Address: ______________________________________ **City:** ____________________

State: ______ **Zip:** __________ **Home Phone:** ______________ **Cell Phone:** ______________

Email: ________________________ **Employer's Name:** ____________________________

Employer's Address: __________________________________ **Work Phone:** ______________

Father/Guardian's Name: ________________________ **Is address different than child's?** Yes No

Address: ______________________________________ **City:** ____________________

State: ______ **Zip:** __________ **Home Phone:** ______________ **Cell Phone:** ______________

Email: ________________________ **Employer's Name:** ____________________________

Employer's Address: __________________________________ **Work Phone:** ______________

Emergency Contact Name: ______________________________ **Relationship to Child:** __________
(Other than Parent/Guadian)

Primary Phone: __________________________ **Cell Phone:** __________________________

Family Physician: ________________________________ **Phone:** ____________________

Primary Insurance: ______________________________ **Policy/Group #:** ________________

General Health *(check those that apply and give appropriate dates)*

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

Date of last health examination: ______________

Since last health examination, has participant had *(check all that apply)*

	Serious injury requiring medical attention?		An illness lasting more than five 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 *(use additional paper as necessary). Include dates.*

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Disease and Immunization History

Which of the following has the participant had? *Attach doctor form or check boxes and list dates.*

	See Attached Doctor Form		Mumps:
	Measles:		Hepatitis A:
	Chicken Pox:		Hepatitis B:
	German Measles:		Hepatitis C:

Immunization Dates are required. You can attach Doctor's 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 Rec'd:
Chicken Pox:			Influenza - Date Rec'd:
Tetan Varicella (chicken pox)			* Immunization Waiver: Parent/Guardian's must attach the completed exemption form.
Polio			
MMR			
Haemophilus Influenza B			
Hepatitis B			

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

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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 Epipen - Doctor's Note Attached: *Yes* *No* / Parent Permission Attached *Yes* *No*		
	Other:		

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 daughter/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 daughter

____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.

Signature: ____ *Date:* __________________