



girl scouts

4300E. Broadway Blvd.
Tucson, AZ 85711
520.327.2288 | 800.331.6782
520.795.3318 fax

Girl Health History Record

Girl's Information

Name			Troop #		
Address			Date of Birth		Age
City	ST	Zip	School		
Parent/Guardian			Home Phone		
Home Address			Daytime Phone		
Business Address			Evening Phone		
Emergency Contact			Relationship		
Address			Phone		
Physician Name			Phone		
Insurance Provider			Policy/Group #		

Illnesses & Injuries, Chronic or Recurring Illness *Check all that apply*

<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Bleeding/clotting disorder	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart defect/disease	<input type="checkbox"/> Musculoskeletal disorder	<input type="checkbox"/> Seizure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Other <input type="text"/>			

Date of last health examination: Complicated medical problems were noted in last health examination
 Participant is currently under the care of a physician or psychologist

Since last health examination, participant has had:

<input type="checkbox"/> A serious injury requiring medical attention	<input type="checkbox"/> An illness lasting more than five days
<input type="checkbox"/> Any prescribed or over-the-counter medication	<input type="checkbox"/> A surgical operation or fracture
<input type="checkbox"/> Treatment in a hospital or emergency room	<input type="checkbox"/> Any restrictions concerning physical activities

Please explain any 'yes' answers to the above questions, including dates:

Allergies *Check all that apply and specify nature of allergic reaction*

<input type="checkbox"/> Animals <input type="text"/>	<input type="checkbox"/> Medicine/drugs <input type="text"/>	<input type="checkbox"/> Food <input type="text"/>
<input type="checkbox"/> Insect Stings <input type="text"/>	<input type="checkbox"/> Plants <input type="text"/>	<input type="checkbox"/> Hay Fever <input type="text"/>
<input type="checkbox"/> Pollen <input type="text"/>	<input type="checkbox"/> Other <input type="text"/>	

Other Health Conditions *check all that apply*

- | | | | |
|---------------------------------------|-------------------------------------------------|---------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Sickle cell trait or disease |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Special dietary needs |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Wear glasses or contact lenses |
| <input type="checkbox"/> Other | <input type="text"/> | | |

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Indicate any activities to be encouraged or restricted. Please attach additional documentation in needed.

Signatures

I know of no reason(s) other than the information indicated on this form, why my child should not participate in prescribed activities except as noted.

<input type="text" value="Adult Signature"/>	<input type="text" value="Date"/>
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EMERGENCY MEDICAL AUTHORIZATION Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while on a Girl Scout activity, when parents and guardians cannot be contacted.

I give my consent for emergency medical treatment of my daughter in the emergency room of the nearest hospital and a certified first aider to provide first aid treatment.

<input type="text" value="Adult Signature"/>	<input type="text" value="Date"/>
<input type="text" value="Phone"/>	