

# Girl Health History Record

Leaders should keep this form in their records and bring to all events.

## Girl's Information

name		date of birth		age	troop #
address		city		st	zip
school					
parent/guardian		home phone		evening phone	
home address		city		st	zip
business address				business phone	

## Emergency Contact & Insurance/Physician

name		relationship		phone	
address		city		st	zip
physician's 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"/> Chicken Pox
<input type="checkbox"/> Heart defect / disease	<input type="checkbox"/> Musculoskeletal disorder	<input type="checkbox"/> Seizure	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Intestinal disorders	<input type="checkbox"/> Hernia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Nervous System Disorders	
<input type="checkbox"/> Other:				

date of last health exam

Yes, complicated medical problems were noted in last health examination.  
 Yes, participant is currently under the care of a physician or psychologist

Since last health exam, participant has had:

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

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

## Allergies

Check all that apply and specify nature of allergic reaction.

<input type="checkbox"/> Animals:	<input type="checkbox"/> Plants:
<input type="checkbox"/> Insect stings:	<input type="checkbox"/> Food:
<input type="checkbox"/> Pollen:	<input type="checkbox"/> Hay fever:
<input type="checkbox"/> Medicine / drugs:	<input type="checkbox"/> Other:

## 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"/> Eyesight impairment | <input type="checkbox"/> Speech impairment      |   |   |
| <input type="checkbox"/> Other:              |   |   |   |

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 as needed.

## Over-the-Counter Medication Administrators

girl's name

medicine administrator 1

medicine administrator 2

## OTC Medication

Check all that are approved:

- |                                      |   |   |                                       |
|--------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Actifed     | <input type="checkbox"/> Benadryl       | <input type="checkbox"/> Neosporin        | <input type="checkbox"/> Tylenol      |
| <input type="checkbox"/> Aloe Vera   | <input type="checkbox"/> Cough Medicine | <input type="checkbox"/> Pepto Bismol     | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Antacid     | <input type="checkbox"/> Dramamine      | <input type="checkbox"/> Saline eye drops | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anti-Emitic | <input type="checkbox"/> Lomotil        | <input type="checkbox"/> Sudafed          | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Anti-Nausea | <input type="checkbox"/> Motrin         | <input type="checkbox"/> Sunscreen        |                                       |

## 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.

parent / guardian signature

date

### 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 for a certified first aider to provide first aid treatment.

parent / guardian signature

phone

date

## Authorization for Administering Over-the-Counter Medications

I give permission to the above-named people to administer the above-named over-the-counter medications to my daughter.

parent/guardian signature

date