girl scouts of southern arizona

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.

☐ Ear infection	☐ Bleeding / clotting disorder	☐ Hypertension	☐ Asthma	☐ Chicken Pox
☐ Heart defect / disease	☐ Musculoskeletal disorder	☐ Seizure	☐ Diabetes	
☐ Intestinal disorders	☐ Hernia	☐ Arthritis	☐ Nervous System Disorders	
☐ 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.

☐ Animals:	☐ Plants:
☐ Insect stings:	☐ Food:
☐ Pollen:	☐ Hay fever:
☐ Medicine / drugs:	☐ Other:

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Other Health Conditions

Check all that apply.

☐ Bed wetting	☐ Emotional or behavioral difficulties	☐ Motion sickness	☐ Sickle cell trait or disease
☐ Constipation	☐ Hearing impairment	☐ Sleep disturbances	☐ Special dietary needs
☐ Fainting	☐ Nosebleeds	☐ Menstrual cramps	☐ Wear glasses or contact lenses
☐ Eyesight impairment Other:	☐ Speech impairment		

Please explain any items that are checked. Indicate any information use-ful 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:

☐ Actifed	☐ Benadryl	☐ Neosporin	☐ Tylenol
☐ Aloe Vera	☐ Cough Medicine	☐ Pepto Bismol	☐ Other: _____
☐ Antacid	☐ Dramamine	☐ Saline eye drops	☐ Other: _____
☐ Anti-Emitic	☐ Lomotil	☐ Sudafed	☐ Other: _____
☐ Anti-Nausea	☐ Motrin	☐ 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 certifi ed fi rst aider to provide fi rst 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

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