girl scouts of the colonial coast

HEALTH HISTORY – GIRL

This health history is to be completed and signed by parent(s)/guardian(s).

GIRL & PARENT INFORMATION

Girl name		Group/Troop #		Date of Birth		Age	
Address							
	Street	City		ST	Zip	Home Phone	
Parent/Guardian 1		Work Phone		Other #			
Parent/Guardian 2		Work Phone		Other #			
If a parent/guardian cannot be reached, person to notify in an emergency							
Name		Relationship		Phone			
Phone		Phone					
Name of Pediatrician or Primary Physician				Phone			
Insurance Information							
Carrier/Company		Member/Patient Services Phone #					
Insurance ID/Member #		Policy/Group Number					

GIRL HEALTH HISTORY – *Check all that apply. Add dates and comments below (or on back) for any checked items.*

Allergies				My daughter has permission to take or use the following:
(Specify nature of allergic reaction)		Diseases and Chronic or Recurring Illness or Disease		
☐ Animals		☐ Chicken Pox	☐ Ear Infections	☐ Tylenol/Acetaminophen
☐ Food		☐ Measles	☐ Heart Defect/Disease	☐ Advil/Ibuprofen
☐ Hay Fever		☐ German Measles	☐ Seizures	☐ Sudafed/decongestant
☐ Insect Stings		☐ Mumps	☐ Bleeding Disorders	☐ Benadryl/antihistamine
☐ Medicine/Drugs		☐ Rheumatic Fever	☐ Asthma or breathing problem	☐ Tums/antacid
☐ Plants		☐ Tuberculosis	☐ Hypertension	☐ Robitussin/expectorant
☐ Pollen		☐ Kidney	☐ Musculoskeletal Disorders	☐ Swimmers' Ear or alcohol/vinegar solution
☐ Other (specify)		☐ Diabetes	☐ Sinusitis	
		☐ Arthritis	☐ Other	☐ None of the above

Other Health Information		Immunization History	Year Primary Series Complete	Year of Last Booster
☐ Behavior problems	☐ Developmental problems			
☐ Disabilities	☐ Prescription medications	Diphtheria, Tetanus, Pertussis (DTP, DTaP)		
☐ Constipation	☐ Emotional disturbances			
☐ Menstrual cramps	☐ Hearing impairment	Diphtheria, Tetanus (DT or Td (given after 7 years of age)		
☐ Nosebleeds	☐ Wears glasses or contact lenses			
☐ Sleep disturbances	☐ Special dietary regimen	Poliomyelitis (IPV, OPV)		
☐ Fainting	☐ Bladder or bowel problem	Haemophilus influenza (Type B)		
☐ Bed wetting	☐ Activities to be restricted	Pneumococcal (PCV conjugate)		
☐ Operations	☐ Serious injuries	Measles, Mumps, Rubella (MMR)		
☐ Hospitalizations	☐ Other (specify)	Measles (Rubeola)		
☐ Motion Sickness	☐ Sickle cell trait or disease	Rubella		
Swimming Ability		Mumps		
☐ Non-Swimmer ☐ Beginner Swimmer ☐ Advanced Swimmer		Hepatitis B Vaccine (HBV)		
Comments:		Varicella Vaccine		
		Other		
Additional Information on back ☐ Yes ☐ No				

PARENT STATEMENT & PRIVACY STATEMENT: This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except noted. All health records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. This information will be held in limited access by the troop leader/health care supervisor for the event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. I have read the above information and agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

PARENT AUTHORIZATION: If my child needs medical treatment, I authorize the adult in charge, should it be necessary, to secure the service of a doctor at my expense. I give my permission for her to be attended for care. I am aware that I will be contacted in the case of an emergency.

Parent/Guardian Signature		Date	
Original signature required, please print & sign			
Year two Signature		Date	