



# Girl Scouts Girl Health History Record

ALL INFORMATION TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN OF GIRL ANNUALLY

## PART I: GIRL RECORD

Girl's Name _____	School Attending _____	Birth Date _____	Troop Number _____
Address/City/State/Zip _____		Family E-Mail Address (For GSNC use only) _____	
Mother's Name _____	Day Time Telephone ( ) _____	Evening Phone ( ) _____	
Father's Name _____	Day Time Telephone ( ) _____	Evening Phone ( ) _____	

Is your girl/ward disabled?  NO  YES      If YES, does she need accommodation?  NO  YES

Do we have your permission for your child/ward to receive emergency medical treatment if needed?  NO  YES

**HEALTH INFORMATION PRIVACY STATEMENT**

The Girl Health History Record is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. *I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.*

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Northern California to seek treatment for my child and/or dependent minor or myself by a licensed physician pursuant to Section-6910 of the Civil Code of California. I know of no reason(s), other than the information indicated on this form, why my daughter/dependent or I should not participate in prescribed activities

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Telephone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

### PART II: EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN

Name _____	Day Time Telephone ( ) _____	Evening Phone ( ) _____
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### PART III: HEALTH INSURANCE INFORMATION

Name of family DENTIST: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Name of family PHYSICIAN: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Family Medical/Hospital INSURANCE CARRIER: \_\_\_\_\_ POLICY/GROUP NUMBER: \_\_\_\_\_

### PART IV: ALLERGIES/ILLNESSES/INJURIES

**Allergic Reaction:** (Check those that apply and specify nature of allergic reaction)  Check here for no known allergies

Animals \_\_\_\_\_  Hay Fever \_\_\_\_\_  Medicines/Drugs \_\_\_\_\_  Pollen \_\_\_\_\_

Food \_\_\_\_\_  Insect Stings \_\_\_\_\_  Plants \_\_\_\_\_  Other (specify) \_\_\_\_\_

**Chronic or Recurring Illnesses:** (Check those that apply and give appropriate dates)  Other Chronic/Recurring Illnesses (specify) \_\_\_\_\_

Asthma \_\_\_\_\_  Diabetes \_\_\_\_\_  Heart Defect/Disease \_\_\_\_\_  Musculoskeletal Disorder \_\_\_\_\_

Bleeding/Clotting Disorders \_\_\_\_\_  Ear Infection \_\_\_\_\_  Hypertension \_\_\_\_\_  Seizures \_\_\_\_\_

Date of last health examination: \_\_\_\_\_ Were any complicating medical problems noted in last health examination?  NO  YES

If YES, what? \_\_\_\_\_

**Other Health Conditions:** (Check those that apply)  Other (specify): \_\_\_\_\_

Attention Deficit Disorder (ADD)  Down's Syndrome  Hearing Impairment  Nose Bleeds  Wears Glasses/Contacts

Bed Wetting  Emotional Disturbances  Menstrual Cramps  Sickle Cell Trait/Disease  Special Dietary Regimen

Dental Braces  Fainting  Motion Sickness  Sleep Disturbances  Visual Impairment

### PART V: MEDICATION

Is your girl taking any medications?  NO  YES

If YES, list medication, reason, and possible side effects.

MEDICATION	REASON	POSSIBLE SIDE EFFECTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

Activity Restrictions?  NO  YES

If YES, list restrictions.

\_\_\_\_\_

\_\_\_\_\_

### PART VI: IMMUNIZATION HISTORY

The following is my girl's immunization history:

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P. _____ <small>Diphtheria, tetanus and pertussis (whooping cough)</small>	_____	_____
Td _____	_____	_____
Measles _____	_____	_____
Mumps _____	_____	_____
Rubella (German measles) _____	_____	_____
Polio _____	_____	_____
Hbpv _____	_____	_____
Tuberculin Test (most recent)....	_____	Result: _____
Other (Specify): _____		

I/We have chosen not to immunize my/our girl.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please review this form annually. If there are no changes or just minor adjustments, please mark those, then sign and date the form.

Forms Bank/Health Forms/HH\_Girl\_Health\_History.doc 09/2008

Updated _____	Date _____
Updated _____	Date _____
Updated _____	Date _____