

Girl Scouts of Southern Alabama, Inc.



Girl Scouts®

Girl Health History Form

Contact Information

Girl Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Troop# \_\_\_\_\_ S.A. \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

Father's Name \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

Emergency Contact (not parent/guardian)

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Medical Information

Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_ Policy/Group# \_\_\_\_\_

If Military Dependent, give location and I.D. number of child's medical records \_\_\_\_\_

<u>General Information:</u>	yes	no	<u>Allergies:</u>	yes	no	<u>Special Needs:</u>	yes	no
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Disability	<input type="checkbox"/>	<input type="checkbox"/>
Corrective eye wear	<input type="checkbox"/>	<input type="checkbox"/>	Poison Oak, etc.	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Physical Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Animals	<input type="checkbox"/>	<input type="checkbox"/>	Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>
Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>	<input type="checkbox"/>	Other Special Needs	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>						
Fainting	<input type="checkbox"/>	<input type="checkbox"/>						
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>						

If you checked yes to any of the boxes, please explain: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_ Date of last TB skin test: \_\_\_\_\_

List any restrictions or special instructions: \_\_\_\_\_

List current medications (including over-the-counter): \_\_\_\_\_

All medications must be in their original container, accompanied by written instructions from the parent or physician, and given to the troop leader.

*This health history is complete and accurate. If circumstances change, I will notify the leader immediately. The health of the girl is primarily the responsibility of her parents or guardians. The Girl Scout organization strongly recommends annual health examinations, dental check-ups, and immunizations against preventable diseases.*

SIGNATURE of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Please complete reverse side.

# Girl Health History Form Continued

## MEDICAL RELEASE

To Whom It May Concern:

I, the undersigned parent, or legal guardian of, \_\_\_\_\_ a minor, do hereby consent to any surgical or medical treatment or procedures which may be suggested, recommended, prescribed, or directed by a duly licensed physician in their competent medical judgment as reasonably necessary for my minor child and where any delay in treatment of my child could reasonably be expected to jeopardize the life or health or could reasonably result in disfigurement or impairment to faculties or if the delay would cause undue psychological or emotional distress to my child.

It is understood that this authorization is given in advance of any specific need for its use by a physician who in the exercise of his best medical judgment may deem it advisable to proceed in treating my child. It is understood that every effort shall be made to contact the undersigned prior to treatment, but the undersigned specifically directs that treatment not be withheld if the undersigned cannot be reached.

I further authorize GIRL SCOUTS OF SOUTHERN ALABAMA, INC. or its designee to sign any form required by law evidencing my consent.

My child has permission to engage in all activities, except as noted by me.

List any restrictions \_\_\_\_\_

This consent shall remain effective from \_\_\_\_\_ to \_\_\_\_\_  
(MM/DD/YY) (MM/DD/YY)

NOTE TO MEDICAL AUTHORITY: As a member of Girl Scouts of the USA, this person is covered by a secondary accident insurance with Mutual of Omaha.

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