



Confidential Health History

This form must be completed and signed by parents/guardians of girls or by adult members themselves. All health history forms will be held in limited access by the trustee (leader/facilitator/staff) of the specific Girl Scout program. The absolute minimal necessary information may be shared with program staff/volunteers in order to provide adequate health care. The health history form will be retained by the Girl Scout program trustee until it is destroyed.

SECTION A: MEMBER INFORMATION

Name _____ Date of Birth _____ Age _____ Troop # _____

Address _____

Parent/Guardian _____ Phone (_____) _____

Home Address _____ City _____ Zip Code _____

Business Address _____ Phone (_____) _____

If Parent/Guardian is unavailable, contact: _____ Relationship _____

Address _____ Phone (_____) _____

Name of family physician _____ Phone (_____) _____

SECTION B: HEALTH HISTORY/RECURRING CONDITIONS

Check each applicable item, giving appropriate dates and comments

<p>ALLERGIES / DESCRIPTION</p> <input type="checkbox"/> Foods _____	<p>ADDITIONAL INFORMATION</p> <input type="checkbox"/> Operation/Date _____	<p>RECURRING CONDITIONS</p> <input type="checkbox"/> Ear Infections _____	<p>DISEASES / DATES</p> <input type="checkbox"/> Chicken Pox _____
<input type="checkbox"/> Insects _____	<input type="checkbox"/> Serious injury/Date _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Measles _____
<input type="checkbox"/> Plants _____	<input type="checkbox"/> Sleepwalking _____	<input type="checkbox"/> Kidney Ailment _____	<input type="checkbox"/> German Measles _____
<input type="checkbox"/> Drugs _____	<input type="checkbox"/> Bedwetting _____	<input type="checkbox"/> Convulsions _____	<input type="checkbox"/> Mumps _____
<input type="checkbox"/> Animals _____	<input type="checkbox"/> Fainting _____	<input type="checkbox"/> Bronchitis _____	<input type="checkbox"/> Scarlet Fever _____
<input type="checkbox"/> Hay fever _____	<input type="checkbox"/> Constipation _____	<input type="checkbox"/> Frequent Colds _____	<input type="checkbox"/> Rheumatic Fever _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Night Disturbances _____	<input type="checkbox"/> Frequent Sore Throat _____	<input type="checkbox"/> Poliomyelitis _____
<input type="checkbox"/> Latex _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Stomach Upset _____	<input type="checkbox"/> Whooping Cough _____
<input type="checkbox"/> Other _____		<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Other _____
<p>DATE OF LAST HEALTH EXAMINATION: _____ / _____ / _____</p> <p>Were any complicating medical problems noted? _____</p> <p>Is participant now under the care of a physician/psychologist? _____</p> <p>List restrictions to swimming, diving, running, etc. _____</p> <p>Describe any medical/dietary regimen to be continued: _____</p>		<input type="checkbox"/> Hyperactivity _____	<p>IMMUNIZATIONS / DATES</p> <input type="checkbox"/> DPT _____
<p>SINCE LAST HEALTH EXAM, HAS THE PARTICIPANT HAD:</p> <p>A serious illness requiring medical attention? _____</p> <p>An illness lasting more than 5 days? _____</p> <p>A surgical operation or fracture? _____</p> <p>Treatment in a hospital or emergency room? _____</p> <p>Any restrictions concerning physical activities? _____</p> <p>Exposure to a contagious disease? _____ Within the past month? _____ What? _____</p>		<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Oral Polio _____
		<input type="checkbox"/> Hearing Impairment _____	<input type="checkbox"/> Measles _____
		<input type="checkbox"/> Vision Impairment _____	<input type="checkbox"/> Td (Adult Tetanus) _____
		<input type="checkbox"/> Orthopedic Impairment _____	<input type="checkbox"/> Mumps _____
		<input type="checkbox"/> Learning Disability _____	<input type="checkbox"/> Rubella _____
		<input type="checkbox"/> Other _____	<input type="checkbox"/> Tuberculin Test _____
			<input type="checkbox"/> Tetanus _____
			<input type="checkbox"/> Hib _____
			<input type="checkbox"/> Hepatitis B _____
			<input type="checkbox"/> Other _____

THIS FORM MUST BE SIGNED
DUPLICATE THIS FORM AS NEEDED

SECTION C: PARENT/GUARDIAN MUST COMPLETE THE INFORMATION BELOW

I have read the above procedures for handling my/my daughter's health history information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. In case of emergency, I give permission for the First Aider(s) to administer medication, and/or First Aid AND give permission to an attending physician to hospitalize or secure proper treatment/surgery for me/my child. I give permission to transport me/my child to the nearest emergency facility for treatment. I know of no reason(s), other than the information indicated on this form, why I/my child should not participate in prescribed activities except as noted.

Signature of parent/guardian _____ Date _____