



NOTE: This form must be completed and signed by parents/guardians of girls. 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.

Girl Health History Form

Name _____

Address _____

City _____ State _____ Zip Code _____

Preferred Phone _____ Birth Date _____

Name of Family Physician _____

Physician's Phone _____ Date of Last Exam _____

Name of Insurance Company _____

Policy or Group No. _____

Major Health Conditions (check all that apply)

- Bleeding/Clotting problems
- Hypertension
- Asthma
- Seizures
- Heart problems
- Hypoglycemia
- Bone/Joint problems
- Diabetes
- Sickle Cell trait or disease
- Other (specify) _____

Allergies (check all that apply and specify nature of allergic reaction)

- Animals _____
- Hay fever _____
- Medicines _____
- Pollen _____
- Food _____
- Insect stings _____
- Plants _____
- Other (specify) _____

Other Health Conditions (check all that apply)

- Bed wetting
- Emotional problems
- Hearing problems
- Constipation
- Speech problems
- Menstrual cramps
- Nosebleeds
- Fainting
- Wears glasses/contact lenses
- Sleeping problems
- Motion sickness
- Ear infections
- Special dietary needs _____
- Other (specify) _____

Please explain any items that are checked. To the best of your knowledge, does this girl have any physical or emotional condition that might prevent her from participating in Girl Scout activities? No Yes (explain)

IMMUNIZATION HISTORY

Please check if immunizations/boosters are up-to-date

- DPT or DT&P (Diphtheria, Pertussis [whooping cough], and Tetanus)
- TD or DT (Diphtheria and Tetanus)
- Measles
- Mumps
- Rubella (German Measles)
- Combined MMR (Measles, Mumps, and Rubella)
- Hib (Haemophilus influenzae type b)
- Polio
- Hepatitis B (HB)
- Tuberculin Test: Result _____
- Other (e.g., Varicella – chicken pox) _____

Emergency Contact

Emergency Contact Name: _____

Relationship to Adult: _____

Contact Primary Phone: _____

Contact Secondary Phone: _____

Girl Scouts of Greater Chicago and Northwest Indiana

Girl Health History Form

I know of no reason(s), other than the information indicated on this form, why my daughter/ward should not participate in prescribed activities except, as noted.

I do hereby authorize the treatment by a qualified and licensed medical doctor for my daughter/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger her life, cause disfigurement, physical impairment, or undue discomfort, if delayed. It is understood that every effort will be made to contact the undersigned prior to rendering treatment, but treatment will not be withheld if the undersigned cannot be reached.

Providing false or incomplete information is a serious matter that may result in liability for damages and/or fraud.

Signature of parent/guardian Date

Signature of parent/guardian Date

Signature of parent/guardian Date

Please update and sign this form annually. Initial and date any changes.

Consent for Release of Personal and Health Information

New compliance form for Health Insurance Portability Accountability Act (HIPAA)

I authorize the use or disclosure of personal and health (includes medical, dental, and pharmacy) information by Girl Scouts of Greater Chicago and Northwest Indiana, as described below:

Any and all personal and health information Girl Scouts of Greater Chicago and Northwest Indiana maintains (including mental health, HIV, and/or substance abuse records – cross out any item you do not authorize to be released). *Note: This consent form allows personal and health information to be shared via a telephone call with the person being authorized.*

This information may be disclosed to, and used by, the following individuals or organizations, including any medical personnel listed on health history portion, or any medical personnel attending to me during a medical emergency.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Girl Scouts of Greater Chicago and Northwest Indiana.

I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will apply while I am a member of Girl Scouts of Greater Chicago and Northwest Indiana.

I understand that I do not have to sign this authorization and that Girl Scouts of Greater Chicago and Northwest Indiana may not condition treatment on whether I sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of member, legal representative, or parent/guardian, if under 18 years of age:

Name: _____ Date: _____

If signed by legal representative or guardian, relationship to member:

Relationship: _____

If signed by legal representative, please provide representative documentation as required by state law, i.e., Power of Attorney, Health Care Surrogate, Living Will, or guardianship papers.