

GIRL HEALTH HISTORY

Program Year 20____ to 20____

Name (Last, First, Initial)		Parent or Guardian		Phone	Cell Phone	
Address		City or Town	State	Zip	Birth date	Age
In Emergency Notify		Address			Phone	

Insurance Information, please complete the following:

Carrier	ID Number	Group Number
Name of Family Physician		Address

Health History: (Check those that apply)

Had any recent injury, illness, or infectious diseases? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Immunizations	Dates	Allergies	Chronic or Recurring Illness	Diseases
<input type="checkbox"/> DTAP <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hib <input type="checkbox"/> M.M.R. <input type="checkbox"/> Oral Polio <input type="checkbox"/> Tetanus, date of last _____	_____ _____ _____ _____ _____	<input type="checkbox"/> Animals <input type="checkbox"/> Food <input type="checkbox"/> Hay Fever <input type="checkbox"/> Insect Stings <input type="checkbox"/> Medicine/Drugs <input type="checkbox"/> Plants <input type="checkbox"/> Pollen <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney

Immunization history is current; primary series completed on _____; year of most recent booster is _____.

Please describe conditions and give dates:

Operations or serious injuries: _____
 Hospitalizations: _____
 Other diseases/disabilities: _____

Comment where applicable:

Fainting _____	Sleep disturbances _____
Bed wetting _____	Menstrual cramps _____
Constipation _____	Nosebleeds _____
Emotional disturbances _____	Other _____
Specific activities to be encouraged _____	Restricted _____

Special medical or dietary regimen to be followed (specify) _____

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as I noted.

Signature of Parent/Guardian _____ Date _____

HEALTH INFORMATION PRIVACY STATEMENT

The Girl Health Examination 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 form 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 form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I hereby give my permission to the adult staff of the Event/Troop to secure emergency medical and surgical treatment for _____, a minor child, while in attendance. I also give consent for routine, non-surgical care.

SIGNATURE: _____ DATE: _____

Parent/guardian

GIRL SCOUTS OF MICHIGAN SHORE TO SHORE OVER-THE-COUNTER MEDICATION PERMISSION

PARENTS: Please indicate below which over-the-counter medications and preparations may be dispensed to your daughter on an as needed basis while she is on her trip. **Please return this completed form to the Troop Leader.**

Full Name (please print): _____

Medication/Preparation	Please initial here for each medication/ preparation we may administer.	Notes:
Acetaminophen (Tylenol)	_____	_____
Ibuprofen	_____	_____
Calamine/Caladryl lotion	_____	_____
Hydrocortisone ointment	_____	_____
Skin Cleansing Agent	_____	_____
Topical (skin) antibiotic	_____	_____
Eye/ear irrigation solution	_____	_____
Cough/cold/allergy medication	_____	_____
Cough drops/throat lozenges	_____	_____
Benadryl	_____	_____
Ice and warm packs	_____	_____
Sunburn preparation/Aloe lotion	_____	_____
Indigestion/diarrhea medication	_____	_____
Earache Medication	_____	_____
Sore throat medication	_____	_____
Toothache medication	_____	_____

Signature of Parent/Guardian

Date

Daytime Phone

Evening Phone

MEDICATION LOG

List your daughter's/ward's medication: Please list the name of the medication and time(s) that your daughter/ward takes her medication.

All prescription medications brought on the trip, must be in their original container, bearing the pharmacy label, showing the prescription number, date filled, physician's name, name of medication, directions for use and patient name. Any over-the-counter medication, cough syrup, vitamins, herbs, etc should be in its original container clearly marked with your daughter's name. We cannot accept medication NOT in its original container.

Medication	Breakfast	Lunch	Dinner	Night	Other
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