

Girl Health History

All information to be completed and signed by parent/guardian annually

Part 1: Girl Record

Girl's Name: _____ Birth Date: _____ School Attending: _____ Troop #: _____

Address/City/Zip: _____ Family Email: _____

Mother's Name: _____ Evening Phone: _____ Cell Phone: _____

Father's Name: _____ Evening Phone: _____ Cell Phone: _____

Does your daughter/ward have a special need? If yes, does she need accommodations?
 No Yes No Yes Please explain: _____

Do we have your permission for your daughter/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: _____

I give permission for my daughter to receive treatment for routine medical and/or first aid needs as outlined in the Treatment Protocols and for the administration of prescribed medications. I understand that 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 give emergency medical and surgical treatment and hospitalization as necessary for my child and/or dependent minor 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 should not participate in prescribed activities.

Parent/Guardian Signature: _____ Date: _____ Phone: _____ Cell Phone: _____

Part 2: Emergency Contact Other than Parent

Name: _____ Daytime Phone: _____ Evening/Cell Phone: _____

Part 3: Insurance Information

Name of Dentist: _____ Phone: _____

Name of Doctor: _____ Phone: _____

Insurance Carrier Name: _____ Policy/Group Number: _____

Part 4: Allergies/Illnesses/Injuries

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

Animals Hay Fever Medicine/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 medical problems noted? No Yes If Yes please explain _____

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 5: Medications

Is your child taking any medications? No Yes
 If Yes, list medication, reason, and possible side effects:

Medication	Reason	Possible Side Effects

Activity Restriction? No Yes

If Yes, please list restrictions:

Please review this form annually. If there are no changes Sign and date the form

Updated by: _____ Date: _____
 Updated by: _____ Date: _____
 Updated by: _____ Date: _____

Part 6: Immunization History

The following is my child's immunization history:

Immunization	Year Primary Series	Year of last Booster
D.T.P (Diphtheria,Tetanus,Pertussis)	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella(German Measles)	_____	_____
Polio	_____	_____
Hbpv	_____	_____
Tuberculin Test	_____	Result

I/ We have chosen not to immunize my/our child

Parent/Guardian Signature: _____ Date: _____