girl scouts of northern california
Girl Scouts of Northern California with offices in:
Alameda, Chico, Eureka, Redding, San Jose, Santa Rosa
T (800) 447-4475
F (510) 633-7925
www.GirlScoutsNorCal.org

Girl Health History Record with Physical

Parent: *Complete form through Part 8 – Health Information Privacy Statement section on back of form*
Physician*: Complete Part 9 – Record of Health Examination on back of form*

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? ☐ No ☐ Yes
If yes, does she need accommodations? ☐ No ☐ Yes
Please explain:

Do we have your permission for your daughter/ward to receive emergency medical treatment if needed? ☐ No ☐ Yes

Part 2: Emergency Contact Other than Parent

Name: Daytime Phone: Evening/Cell Phone:

Part 3: Health 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

Please list any current physical, mental, or psychological health conditions requiring medical treatment, special restriction or considerations:

Please list any dietary restrictions or special considerations:

Please list any previous medical treatments, operations, or serious injuries; provide date:

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:

Part 6: Immunization History

☐ The following is my child's immunization history:

Immunization	Year Primary Series	Year of last Booster
D.T.P (Diptheria,Tetanus,Pertussis)		
Td (Tetanus, Diphtheria).....		
Measles.....		
Hepatitis B.....		
Tetanus.....		
Mumps.....		
Rubella(German Measles).....		
Oral Polio.....		
Inject able Polio.....		
Tuberculin Test.....		Result

☐ I/ We have ...chosen not to immunize my/our child
Parent/Guardian Signature: Date:

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with child's name, address, dosage, & Frequency. Please label over the counter medications with name and dosage.

Part 7: Parent Consent

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:**

Part 8: 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:**

Part 9: Record of Health Examination

To be completed within 24 months of camp attendance by a licensed physician –
MD, Physician's Assistant or nurse practitioner acting under the supervision of a licensed MD

I have examined the above applicant within the past 24 months. Date of exam:

In my opinion, the above applicant's condition ☐ Does ☐ Does Not preclude her participation in an active program.

Activities to be limited:

The applicant is under the care of a physician for the following condition:

Current treatment (including medications):

Height: Weight: Blood Pressure:

Name of Physician:

Signature of Physician:

Phone:

Date Signed:

Doctor's Office Stamp or Address