girl scouts nation's capital

Girl Health History and Emergency Medical Authorization Form

This form must be completed annually and as changes occur by the child's parent or guardian and returned to the troop leader and/or troop first-aider prior to attending the first troop meeting. Use additional paper if needed.

Child's Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ School: _____ Grade: _____ Troop Number: _____

PARENT/GUARDIAN INFORMATION

Child is in the custodial care of: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other: _____

Parent/Guardian 1: _____ Address (if different than child's): _____

Phone 1: _____ Phone 2: _____ Phone 3: _____ E-mail: _____

Parent/Guardian 2: _____ Address (if different than child's): _____

Phone 1: _____ Phone 2: _____ Phone 3: _____ E-mail: _____

EMERGENCY CONTACTS

Name: _____ Relationship: _____ Phone 1: _____ Phone 2: _____ Phone 3: _____

Name: _____ Relationship: _____ Phone 1: _____ Phone 2: _____ Phone 3: _____

HEALTH INFORMATION (Check all that apply and provide requested information)

Allergies	Yes	No	Explain "yes" answers. Include the type of allergy (e.g.- "nut allergy" in the food category)
Animals	☐	☐	
Insect Stings	☐	☐	
Plants/Trees	☐	☐	
Food	☐	☐	
Drugs	☐	☐	
Other	☐	☐	

	Condition	Dates		Condition	Dates		Condition	Dates
☐	ADD/ADHD		☐	Epilepsy		☐	Muscle Disease/Disorder	
☐	Arthritis		☐	Fainting		☐	Nervous System Disorder	
☐	Asthma		☐	German Measles		☐	Sickle Cell Anemia	
☐	Athletes Foot		☐	Hay Fever		☐	Sinusitis	
☐	Bed Wetting		☐	Headaches/Migraines		☐	Skeletal Disease/Disorder	
☐	Bleeding/Clotting Disorder		☐	Hearing		☐	Skin Conditions	
☐	Bronchitis		☐	Heart Defect/Disease		☐	Sleep Disturbance/Walking	
☐	Chicken Pox		☐	Hypertension		☐	Stomach Upsets	
☐	Colds/Sore Throats		☐	Kidney Disease		☐	Urinary Tract Infections	
☐	Constipation		☐	Measles		☐	Wear: ☐Contacts ☐Glasses	
☐	Convulsions		☐	Mononucleosis		☐	Other: _____	
☐	Diabetes		☐	Motion Sickness		☐	Other: _____	
☐	Ear Infections		☐	Mumps		☐	Other: _____	

Explain any specific needs or accommodations required: _____

Explain any known behavioral and/or emotional problems: _____

Explain any psychiatric counseling or hospitalization: _____

Explain any operations or serious injuries: _____

Explain any disabilities or chronic or recurring illnesses: _____

Explain any activities that are discouraged or limited by your child's physician: _____

Explain any dietary modifications: _____

Has menstruation begun? ☐Yes ☐No If not, does she know what it is? ☐Yes ☐No If yes, is her menstrual history normal? ☐Yes ☐No

Since her last health exam, has your child had:	Yes	No	Explain "yes" answers. Provide details and dates.
A serious injury requiring medical attention?	☐	☐	
An illness lasting longer than one week?	☐	☐	
An in-patient hospital or emergency room treatment?	☐	☐	
Restrictions from participating in any activities?	☐	☐	

Date of Last Health Exam: _____ Current Height: _____ Current Weight: _____

IMMUNIZATION HISTORY

Are all immunizations current? ☐ Yes ☐ No If not, state reason(s): _____ DTP or DT (Tetanus) Date: _____

MEDICATION INFORMATION

Are any prescription medications being taken? ☐ Yes ☐ No Are any of the following used? ☐ Inhaler ☐ EpiPen

Name of Medication	Reason for Medication	Dosage	Frequency

My child may be given: ☐ Aspirin ☐ Benadryl ☐ Ibuprofen ☐ Neosporin ☐ Tylenol ☐ None

MEDICAL CARE AND INSURANCE INFORMATION

Physician: _____ Phone: _____ Dentist/Orthodontist: _____ Phone: _____

Preferred Medical Facility: _____ Address: _____

Insurance Company: _____ Policy #: _____ Policy Holder: _____

Company Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION FOR MEDICAL CARE

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First-Aider or Adult-In-Charge to provide routine health care and witness prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by Girl Scouts of the USA, Girl Scouts Nation's Capital, or individual units. Should a medical emergency arise during my child's participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Signature: _____ Date: _____

* If for any reason you cannot sign this form, attach a written statement to this form. The statement must be signed for attendance/participation.