girl scouts of northern indiana-michiana

Girl Health History

This health history record/consent for emergency medical treatment form should be completed by a Girl Scout caregiver and returned to the troop leader. The troop leader will keep this form with the troop's permanent files. For each additional Girl Scout year please have caregivers review and make the necessary updates, initial and date the last page of the form. Please complete a new form if there are numerous or important changes.

Girl Scout's Name _____

Address _____

City _____State_____ZIP_____

Phone_____School_____Troop # _____

Date of Birth_____Grade_____

Caregiver #1 _____ Daytime Phone _____

Caregiver #2 _____ Daytime Phone _____

If a caregiver cannot be reached, person (adult) to notify in an emergency

Name _____ Relationship _____

Phone number(s) _____

Physician/Insurance Information

Family Physician _____ Phone _____

Family dentist/orthodontist_____ Phone _____

Family medical/hospital insurance carrier _____

Policy or Group number _____

Part I: Illness and injuries (check all that apply)

❑ Ear infection	❑ Bleeding/clotting disorders	❑ Hypertension	❑ Asthma
❑ Heart defect/disease	❑ Musculoskeletal disorders	❑ Seizures	❑ Diabetes
❑ Hypoglycemia	❑ Other:		

_____

Date of last health examination: _____

What, if any, complicating medical problems were noted?

_____

Part II. Allergies (check all that apply and specify the nature of the allergy)

❑ Hay Fever/Pollen: _____ ❑ Insect Stings: _____

❑ Food: _____ ❑ Plants: _____

❑ Medicine/Drugs: _____ ❑ Other: _____

Part III. Other Health Conditions (check all that apply)

❑ Bedwetting ❑ Constipation ❑ Fainting ❑ Hearing Impairment ❑ Menstrual Cramps

❑ Motion sickness ❑ Nosebleeds ❑ Sickle Cell trait/disease ❑ Special Diet regimen

❑ Sleep disturbances ❑ Glasses or contacts ❑ ADD & ADHD ❑ Other:

_____

If you checked any of the above, please explain any details we should know:

_____

_____

Part IV. Immunization History

	Years primary series completed	Year of last booster
DTP/DTaP	_____	_____
TD (tetanus/diphtheria)	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella/German measles	_____	_____
Hib	_____	_____
Tuberculin Test, most recent:	_____	
Other	_____	_____

Part V. Current Medications

This person ❑ takes **NO** medications on a routine basis

❑ Takes prescription/over-the-counter medications as follows:

Med #1 _____ Dosage _____

Specific times taken _____ Reason for taking _____

Med #2 _____ Dosage _____

Specific times taken _____ Reason for taking _____

Attach additional pages for more medications or additional medication information.

Consent for Emergency Medical Treatment

I/we do hereby state that I/we are the parent/ legal caretaker of the above-named minor. In case of my/our unavailability, I/we authorize the Girl Scout leader or adult in charge to consent to any necessary health care including: examination, medical diagnosis, anesthetic, surgery, or other treatment, and/or hospital care to be rendered to the above mentioned minor under the supervision of and/or advice of a licensed physician.

Caretaker Signature_____Date_____

Caretaker Signature _____Date_____

Please use this area to further explain any items checked and provide any information that would be useful to the adult(s) in charge. Please also tell us about any activities that should be encouraged or restricted.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Caretaker initials that information on this form is still current _____ Date_____
Caretaker initials that information on this form is still current _____ Date_____
Caretaker initials that information on this form is still current _____ Date_____
Caretaker initials that information on this form is still current _____ Date_____
Caretaker initials that information on this form is still current _____ Date_____