girl scouts of northern indiana michiana

Girl Health History

*This health history record/consent for emergency medical treatment form should be **completed each Girl Scout year** by a Girl Scout's parent or guardian and returned to the troop leader. The troop leader will keep this form with the troop's permanent files. Please use additional paper if needed.*

Girl Scout's Name _____

Address _____

City _____State_____ZIP_____

Phone _____ School _____ Troop # _____

Date of Birth _____ Grade _____

Custodial Parent/Guardian #1 _____ Daytime Phone _____

Custodial Parent/Guardian #2 _____ Daytime Phone _____

If a custodial parent/guardian cannot be reached, person (adult) to notify in an emergency

Name _____ Relationship _____

Phone number(s) _____

At regular troop meetings, the following people are allowed to pick my daughter up, in addition to custodial parents/guardians (Use additional sheet if needed. Please inform leaders in writing of any changes throughout the year.)

Name _____ Relationship_____ Phone number(s) _____

Name _____ Relationship_____ Phone number(s) _____

If there is a person(s) who specifically or legally may NOT pick up your daughter, please let us know:

Name _____ Relationship _____

Name _____ Relationship _____

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? _____

Northern Indiana Service Center: 10008 Dupont Circle Drive E, Fort Wayne, IN 46825
Michiana Service Center: 1218 E University Drive, Granger, IN 46530

800.283.4812
Fax: 855.422.0084
www.gsnim.org

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

	Year's primary series completed	Year of last booster
DTP/DTaP	_____	_____
TD (tetanus/diphtheria)	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella/German measles	_____	_____
Oral Polio	_____	_____
Hib	_____	_____
Tuberculin Test, most recent result:	_____	
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 each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

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 custodial parent/legal guardian 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: first aid/CPR performed by certified Girl Scout volunteer, or 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.

Custodial Parent/Guardian Signature _____ Date _____

Custodial Parent/Guardian Signature _____ Date _____

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Please use this area to further explain any items checked on the reverse side/above 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. Please use additional sheets if needed.

_____

_____

_____

_____

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