242 Adelphia Road
Farmingdale, NJ 07727

1405 Old Freehold Road
Toms River, NJ 08753

Girl Scouts of the Jersey Shore
STANDARD HEALTH HISTORY/PERMISSION SLIP
To be filled in by parent/guardian.
Information is confidential and only provided to leader or chaperone in case of emergency.

_______________________________ (____)_________________________________
Girl's Name (Last, First, Initial) Home Phone # Birth date Age

_______________________________ (____)_________________________________
Parent/Guardian's Name Daytime Phone #

____
Address Town State Zip

____(_____)_______________
In Emergency Notify Address Daytime Phone #

____
Medical Insurance ID#

____, (_____)______________________
Name of Pediatrician/Doctor Phone

Date of last physical exam: ______________________

Health History: (check those that apply)

Diseases
_ Chicken Pox
_ Measles
_ German Measles
_ Mumps

Allergies
_ Animals
_ Pollen
_ Hay Fever
_ Insect Stings
_ Medicine/Drugs
_ Plants
_ Food *
_ Other* (Specify)
____
____
____

Chronic or Recurring Illness
_ Ear Infections
_ Heart Defect/Disease
_ Seizures – medication*
_ Bleeding Disorders
_ Asthma – inhaler*
_ Hypertension
_ Diabetes
_ Musculoskeletal Disorders
_ ADD
_ Other* (Specify) ___________
____

Authorization for treatment: In the case of an emergency, I hereby give permission to the physician selected by the leader to secure and administer treatment, including hospitalization for my child as named above.

____
Parent/ Guardian Signature ***Date***

Please describe conditions and give dates:

Operations or serious injuries ____
Hospitalizations ____
Other diseases/disabilities ____
Does your child take any medication regularly? ___________________________________
If so, name of medication ____
for what condition? ____

ALL MEDICATION NEEDS TO BE IN ORIGINAL CONTAINER WITH LABEL

Comments where applicable:

Fainting ____
Menses ____
Constipation____
Nosebleeds____
Emotional disturbances____
Injuries____
Other____
Special medical or dietary regimen to be followed (be specific) ______________________
____

Over the counter medication will ONLY be given if provided by a parent/guardian in the original container with written instructions. Parent will be contacted prior to administering.

List medication____
Number of tablets__________________ Child or Adult_____________

Are there any additional concerns, medical or otherwise, you wish to bring to our attention?
____
____
____

This health history is correct and my child has permission to engage in all prescribed activities, except as noted by me.

____
Parent/ Guardian Signature ***Date***

If no changes from prior year: *Parent/Guardian initial* _________ *Date:* _________
Parent/Guardian initial _________ *Date:* _________
Parent/Guardian initial _________ *Date:* _________