girl scouts of the sierra nevada

Girl and Adult Health History Form
Please print clearly in ink.

☐ Girl Member ☐ Adult Member

CONTACT INFORMATION

Troop #:	Service Unit:	Birthdate: Age:
First Name:	Middle Name:	Last Name:
Mailing Address:		
City:	State:	Zip Code:
Phone: ( )	Cell: ( )	
Email:		
Name of Parent/Guardian:		Phone: ( ) Cell: ( )
Name of Parent/Guardian:		Phone: ( ) Cell: ( )
Custodial Care Information: ☐ Both Parents ☐ One Parent (specify): _____ ☐ Other: _____		
Emergency Contact 1:	Relationship:	Phone: ( ) Cell: ( )
Emergency Contact 2:	Relationship:	Phone: ( ) Cell: ( )
My child **may not** be released to the following person(s):		

HEALTH INFORMATION

Name of Family Physician:		Phone: ( )
Family Medical/Hospital Insurance Carrier:		Policy or Group No:
Family Dental Insurance Carrier:		Policy or Group No:

Does the participant have any chronic and/or recurring illnesses? (Check all that apply)

☐ Asthma	☐ Hypertension	☐ Sinusitis
☐ Bleeding/Clotting Disorder	☐ Kidney Disease	☐ Skeletal Disease/Disorder
☐ Diabetes	☐ Mononucleosis	☐ Urinary Tract Infections
☐ Ear Infections	☐ Muscle Disease/Disorder	☐ Other:_____
☐ Epilepsy	☐ Nervous System Disorder	☐ Other:_____
☐ Heart Defect/Disease	☐ Sickle Cell Anemia	

Does the participant experience any of the following health conditions? (Check all that apply)

☐ ADD/ADHD	☐ Hay Fever	☐ Skin Conditions
☐ Athletes Food	☐ Headaches/Migraines	☐ Sleep Disturbances
☐ Bed Wetting	☐ Hearing Impairment	☐ Stomach Upsets
☐ Constipation	☐ Menstrual Cramps	☐ Motion Sickness
☐ Emotional Disturbances	☐ Motion Sickness	☐ Wears contacts or glasses
☐ Fainting	☐ Nosebleeds	☐ Other: _____

Date of last health examination:

Since the last health examination, has the participant had:	
A serious injury requiring medical attention?	☐ Yes ☐ No Explanation: _____
Treatment in a hospital or emergency room?	☐ Yes ☐ No Explanation: _____
Any exposure to a contagious disease?	☐ Yes ☐ No Explanation: _____
An illness lasting more than five days?	☐ Yes ☐ No Explanation: _____
Restrictions from participating in any activities?	☐ Yes ☐ No Explanation: _____
Surgery?	☐ Yes ☐ No Explanation: _____

HEALTH INFORMATION

Does the participant have any physical, mental, or psychological conditions requiring medication, treatment, restrictions, or special considerations?
☐ Yes ☐ No If yes, please describe:

Does the participant take any prescribed medication or over-the-counter drugs on a regular basis?
☐ Yes ☐ No If yes, please describe:

Is the participant restricted or limited from participating in any physical activity?
☐ Yes ☐ No If yes, please describe:

Does the participant have any dietary restrictions?
☐ Yes ☐ No If yes, please describe:

Are all immunizations current? ☐ Yes ☐ No If no, please state reason:	**Date of last Tetanus shot:**

ALLERGIES

Explain type of allergy, reaction, and management of reaction:		
Animals	☐ Yes ☐ No	
Insect Strings	☐ Yes ☐ No	
Plants/Trees	☐ Yes ☐ No	
Food	☐ Yes ☐ No	
Drugs	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

MEDICATIONS

Are any prescription medications being taken? ☐ Yes ☐ No
If yes, please share the describe the name, dosage, and frequency:

If the participant is a minor, they may be given:

☐ Aspirin
☐ Benadryl (Adult)
☐ Benadryl (Children's)
☐ Calamine and/or Caladryl Lotion
☐ Ibuprofen
☐ Neosporin
☐ Tylenol (Adult)
☐ Tylenol (Children's)
☐ Tums
☐ Pepto Bismol

Are any of the following used by the participant?

☐ Inhaler
☐ EpiPen

AUTHORIZATION

Parent/Guardian Authorization
This health form is complete and accurate. I know of no reason(s), other than the information listed on this form, why my child should not participate in the prescribed activities. If my child needs medical attention while participating in Girl Scout activities, I authorize the adult in charge to see that my child receives routine healthcare, authorized medications, and reasonable first aid. If I cannot be reached in an emergency, I hereby give permission for the adult in charge to secure and consent to treatment and/or emergency services deemed advisable by a licensed physician. I understand every effort will be made to contact me or my designated contact before taking this action.

This authorization shall remain in effect from October 1, 20____, through September 30, 20_____.

Signature of parent/guardian: _____ Date: _____

Adult Member Authorization
This health form is complete and accurate. I am able to engage in all prescribed activities, except as noted.

Signature of adult member: _____ Date: _____