



GIRL SCOUT MEDICAL INFORMATION

Girl Scouts of San Jacinto Council



(THIS FORM MAY BE PHOTOCOPIED WHEN COMPLETED. PRINT CLEARLY, USE BLACK INK.)

Girl's Name _____ Troop/Group # _____ Phone () _____

Home Address _____ City _____ State _____ Zip _____

Date of Birth _____ Date of last Health Exam _____

Girl's Physician/Clinic _____ Phone () _____

Parent/Legal Guardian _____ Phone () _____ Cell Phone () _____

HOSPITAL INSURANCE INFORMATION Attach photocopy of insurance card.

Name of Carrier _____ Policy # _____

Insured's name _____ Member ID# _____

Company name if insured through employer _____ Phone: () _____

Others who could be contacted to authorize treatments:

Name _____ Day() _____ Evn() _____ Relationship _____

Name _____ Day() _____ Evn() _____ Relationship _____

PART I

Allergies (Check those that apply. Specify cause and nature of reactions - e.g. penicillin causes hives.)

Animals Plants Food Medicine/Drugs _____

Hayfever Pollen Insect Sting _____

Other: _____

In case of an allergic reaction, respond by _____

PART II

Health Conditions (Check those that apply.)

Chronic or reoccurring illness: _____

Asthma Musculoskeletal Disorders Kidney Disease

Diabetes Heart Disease/Defects Hypertension

Seizures Bleeding/Clotting Disorder Ear Infection

Other: _____

IN THE LAST YEAR: (ANSWER YES OR NO)

Complicating medical problems/operations? _____ Serious injury/illness requiring medical care? _____

Explain: _____

SPECIFIC INSTRUCTIONS / ONGOING TREATMENTS: _____

PART III

Other Health Conditions (Check those that apply.)

Sleep disturbances Motion sickness Constipation/diarrhea Bedwetting

Hepatitis A / B / C (circle one) Menstrual complications Sickle cell trait or disease ADHD / ADD

Emotional disturbances Hearing impairment Special dietary regiment Fainting

Physical disabilities Frequent headaches Wears contact lenses/glasses Nosebleeds

Orthodontic appliances Eating disorders _____

Other (specify) _____

Please explain. Indicate any information useful to the adult in charge in relation to any of the above health conditions.

Indicate any activity to be encouraged or restricted

Dietary Needs / Restrictions: _____

PART IV

Immunization/Disease History (Please complete or attach a copy of this child's Immunization Record)			
Immunization	Year Primary Series Completed	Year of Last Booster	Has had Disease
D.T.P.			
Diphtheria			
Pertussis (whooping cough)			
Tetanus			
Td (tetanus/diphtheria)			
Measles			
Mumps			
Rubella (German Measles)			
Chicken Pox			
Oral Polio			
Hib			
Hepatitis B			
Tuberculin Test Result (most recent)			
Other			

Listed are medication(s) my child will routinely take with the supervision of the Leader/First Aider. (Attach a list if necessary.)		
Medication:	Dosage:	How Often:

Over the Counter Medication(s):

She can have: _____

She **cannot** have: _____

Parent's/Legal Guardian's Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all planned trip activities except as noted by the examining physician or me.

TRANSPORTATION RELEASE: I authorize transportation for my child by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of my child. It is my expressed intention to hold Girl Scouts of San Jacinto Council harmless for any and all injuries, death or damages arising from or in any way related to any such transportation.

CONSENT TO TREAT: I hereby give permission to the physician selected [by the trip coordinator] to order X-rays, routine tests and treatment for the health of my child, in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the first aider/trip coordinator to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above.

The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to troop/group leaders, drivers, medical personnel, etc.

My signature confirms that the above information is correct to the best of my knowledge and that I am authorized to execute the information form and release.			
Signature of Parent/Legal Guardian	Full Name of Child	Relationship to Child	Date
_____	_____	_____	_____
Print Name of Parent/Legal Guardian	Day () _____	Even () _____	Cell () _____
_____	_____	_____	_____
Address	City	State	
_____	_____	_____	