



Girl Scout Council of the Nation's Capital
 4301 Connecticut Avenue, N.W. Suite M-2
 Washington, D.C. 20008
 PHONE 202-237-1670 800-523-7898
 FAX 202-274-2161
 www.gscnc.org

A130

GIRL HEALTH HISTORY / EMERGENCY MEDICAL AUTHORIZATION FORM

To be filled out by parent/guardian Return Form to: Troop/Group Leader at or before the first meeting. Must be updated yearly or as changes occur.

Child's Name (first, middle initial, last) _____ Troop # _____ Level _____

Birth Date _____ Age _____ School attending _____ State _____ Grade _____

Home address _____ City _____ State _____ Zip _____

Parent or Guardian _____ Phone: Day _____ Cell _____ Evening _____

Home Address _____ City _____ State _____ Zip _____

2nd Parent or Guardian _____ Phone: Day _____ Cell _____ Evening _____

Home Address _____ City _____ State _____ Zip _____

Child is in the custodial care of _____ both parents _____ mother only _____ father only _____ other _____

Emergency Contact: If neither parent/guardian is available in an emergency, contact:

Name: _____ Relationship _____ Phone: Evening _____ Day _____ Cell _____

Name: _____ Relationship _____ Phone: Evening _____ Day _____ Cell _____

Health History: (Check all that apply and give approximate dates. Attach additional sheets as necessary)

- | | | | |
|------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Sickle Cell Anemia _____ | Allergies: |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Fainting _____ | <input type="checkbox"/> Sinusitis _____ | <input type="checkbox"/> Animals _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Skeletal disease/disorder _____ | <input type="checkbox"/> Bee/wasp stings _____ |
| <input type="checkbox"/> Athletes Foot _____ | <input type="checkbox"/> Headaches; Migraines _____ | <input type="checkbox"/> Skin Conditions _____ | <input type="checkbox"/> Plants, ivy/oak _____ |
| <input type="checkbox"/> Bed Wetting _____ | <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Sleep Disturbance/ Walking _____ | |
| <input type="checkbox"/> Bleeding/clotting disorders _____ | <input type="checkbox"/> Heart defect/disease _____ | <input type="checkbox"/> Stomach upsets _____ | <input type="checkbox"/> Drugs _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Urinary Tract Infections _____ | |
| <input type="checkbox"/> Frequent Colds/Sore Throats _____ | <input type="checkbox"/> Kidney Disease _____ | Wears: <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> Foods _____ | |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Mononucleosis _____ | <input type="checkbox"/> Chicken pox _____ | |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Motion Sickness _____ | <input type="checkbox"/> German measles _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Muscle disease/disorder _____ | <input type="checkbox"/> Measles _____ | |
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Nervous system _____ | <input type="checkbox"/> Mumps _____ | |

Are there any special needs or accommodations required? If yes, please explain _____

Are there any known behavioral and/or emotional problems? If yes, explain _____

Ever required any psychiatric counseling or hospitalization? If yes, explain _____

Operations or serious injuries _____

Disability or chronic or recurring illness _____

Activities to be encouraged or limited by her physician? _____

Dietary modifications _____

Has this person menstruated? _____ If not, has she been told about it? _____ If so, is her menstrual history normal? _____

Since her last health exam has your child had: a serious injury requiring medical attention? an illness lasting longer than one week? _____

an in-patient hospital treatment or the emergency room? been restricted from participating in any school activities? _____
 (Please explain any "YES" answers to the above questions and include dates and/or details. May use back of form if necessary.)

Immunization History: Are all immunizations up-to-date? Yes No If no, please state reason _____

(Give date of immunization that the child listed above has had. Complete other information as requested.) DTP or DT (Tetanus) Date: _____

Insurance Information: Company _____ Policy Number _____ Policy Holder _____

Company address: _____ City: _____ State _____

Other: Name of Dentist/Orthodontist: _____ Phone _____

Name of Physician _____ Phone _____ Date of last examination _____

Preferred Medical Facility: _____ Location: _____

Medication Information: Any prescribed medication being taken? No Yes - Inhaler Epipen Other- what, why, when, and dosage? _____

Current Weight _____ Current Height _____ My child may be given (check all that apply): Aspirin Benadryl Neosporin Tylenol None

IMPORTANT – THIS SECTION MUST BE COMPLETED

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First Aider or Adult-in-Charge to provide routine health care and administer prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by GSUSA, GSCNC or individual units. Should a medical emergency arise during my child's participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied for trips and camping outside of the normal meeting place.

Signature of Parent/Guardian (in ink) _____ Date _____

*If for religious reasons you cannot sign this form, then submit a legal waiver, which must be signed for attendance/participation.