



GIRL SCOUTS OF WESTERN NEW YORK, INC.

GIRL HEALTH HISTORY RECORD

Girl Scouts®

*** This form and photo release of girls is to be completed and signed by parent/guardian.**

| | | |
|---------------------------------|--------------------|------|
| Girl's name: | Date of birth: | Age: |
| Address: | Troop #: | |
| Parent/Guardian (father): | Home phone: | |
| Business address: | Business phone: | |
| | Cell phone: | |
| Parent/Guardian (mother): | Home phone: | |
| Business address: | Business phone: | |
| | Cell phone: | |
| In an emergency, notify (name): | Relationship: | |
| Address: | Phone: | |
| | Cell phone: | |
| Name of family physician: | Phone: | |
| Primary insurance carrier: | Policy or group #: | |

Emergency Medical Authorization – In the event reasonable attempts to contact me at the above listed phone numbers have been unsuccessful, I hereby give my consent to the administration of emergency medical treatment by any licensed physician or dentist and to transport the child to any reasonably accessible hospital facility.

* **Parent/Guardian Signature** _____ **Date** _____

Refusal to Consent – I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the persons in charge to take no action or to: _____

* **Parent/Guardian Signature** _____ **Date** _____

Part I: Illnesses and Injuries (check those chronic or recurring illnesses that apply and give appropriate dates)

- Ear infection
- Heart defect/disease
- Bleeding/Clotting disorders
- Musculoskeletal disorders
- Asthma
- Seizures
- Other: _____

Part II: Allergies (check those that apply and specify nature of allergic reaction)

- Animals _____
- Pollen _____
- Medicine/drugs _____
- Plants _____
- Hay fever _____
- Food _____
- Insect stings _____
- Other: _____

Medication: (Prescription or over the counter) will NOT be disbursed unless they are provided by the parent/guardian in original container, placed in a resealable plastic bag labeled with child's name and instructions for dispensing.

Part III: Other Health Conditions (check those that apply)

- Bed wetting
- Constipation
- Hearing impairment
- Sickle Cell trait or disease
- Special dietary regimen
- Wears glasses or contact lenses
- Other: _____
- Emotional disturbances
- Fainting
- Menstrual cramps
- Motion sickness
- Nose bleeds
- Sleep disturbances

| Part IV: Immunization History | Year Primary Series Completed | Year of Last Booster |
|-------------------------------|-------------------------------|----------------------|
| DPT | | |
| Tetanus/Diphtheria | | |
| Tetanus (most recent) | | |
| Oral Polio | | |
| Injectable Polio | | |
| Measles | | |
| Rubella | | |
| Mumps | | |
| T.B. Test | | |
| HBVP | | |
| Other: | | |

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted. _____

I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

***Parent/Guardian Signature** _____ **Date** _____

Photo Release I give permission to the Girl Scout Council of Western New York, Inc. to use photos taken of my daughter participating in Girl Scout activities for the promotion of Girl Scouting.

***Parent/Guardian Signature** _____ **Date** _____