girl scouts of western new york

GIRL HEALTH RECORD

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

GIRL EMERGENCY INFORMATION

Girl's name:	Date of birth: Age:
Address:	Troop #:
City/St/Zip:	SU name/#

Parent/Guardian:	Parent/Guardian:
Business address:	Business address:
Business phone:	Business phone:
Home phone:	Home phone:
Cell phone:	Cell phone:

In an emergency, notify (name):	Relationship:
Address:	Phone:
City/St/Zip:	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: _____

GIRL HEALTH HISTORY

Part I: Illnesses and Injuries

(check those chronic or recurring illnesses that apply)

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

Part II: Allergies *(check those that apply + specify nature of the reaction)*

	Allergen	Reaction		Allergen	Reaction
☐	Animals		☐	Plants	
☐	Pollen		☐	Hay fever	
☐	Medicine/drugs		☐	Food	
☐	Other:		☐	Insect stings	

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

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

(Please use the back of this form to describe further information)

Part IV: Immunization History

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

ADDITIONAL INFORMATION:

Please explain any items that are checked. If a girl scout has any special needs, including disabilities, medicinal requirements, behavioral conditions, or child custody concerns please indicate below & notify the adult in charge. List any activities to be encouraged or restricted.

MEDICATION:

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

PARTICIPATION:

☐ 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: _____

(#350-GG-HLT)