# Girl Scouts of the Green and White Mountains
# Health History and Medical Examination Form for Minors

**Health History:** The more complete information you provide, the better we can work with your child to ensure she receives the care she needs.

**Medical Examination:** A medical examination is completed for trips lasting more than three nights. The examination is completed by a licensed physician, nurse practitioner, physician's assistant, or registered nurse within the preceding 24 months unless a health issue is present.

*Please type or write clearly and legibly.*

| **Name of Minor:** (Last, First, Middle Initial) | **Date of Birth:** (XX/XX/XXXX) | | |
|---|---|---|---|
| **Address:** | **City:** | **St:** | **Zip:** |
| **Parent or Guardian:** | **Phone:** | **Alternate Phone:** | |
| **Parent or Guardian:** | **Phone:** | **Alternate Phone:** | |

**Emergency Contact Information (parent/guardian):**

| **Emergency Contact:** | **Relationship:** |
|---|---|
| **Phone:** | **Alternate Phone:** |

**Health Insurance Information** (Family insurance is primary insurance in case of accident or illness; Girl Scout insurance is secondary.)

| **Policy Holder's Name:** | **Policy Number:** |
|---|---|
| **Insurance Company Name:** | **Group Number:** |
| **Insurance Company Address:** | **Insurance Company Phone:** |

## Check all that apply and explain in detail checked answers:

| | |
|---|---|
| | Diabetes |
| | Heart Defects/Disease |
| | Asthma |
| | Ear Infections |
| | Musculoskeletal Disorders |
| | Convulsions/Epilepsy/Seizures |
| | Sinusitis (Sinus Infections) |
| | Physical Restrictions |

| | |
|---|---|
| | Sleep disturbances |
| | Fainting |
| | Bed wetting |
| | Constipation |
| | Chicken Pox |
| | Measles |
| | German Measles |
| | Mumps |

| | | | | |
|---|---|---|---|---|
| | Kidney/bladder illness | | | Rheumatic Fever |
| | Mental/psychological disorder | | | Tuberculosis |
| | Hypertension | | | Kidney Disease |
| | Arthritis | | | Eating Disorders (Anorexia, Bulimia, etc.) |
| | Nosebleeds | | | Headaches/Migraines |
| | Has begun menstruation | | | Had surgery or hospitalized in the last 5 years |
| | Menstrual cramps | | | Currently under doctor's care |
| | Bleeding disorder | | | Emotional – Separation Anxiety |
| | Other: | | | |

**Please explain in detail all checked answers marked above:**

**Allergies:** Please list all allergies, the type of reaction and its severity, treatment, and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

| Allergies | Reaction/ Severity | Treatment | Date of last Reaction |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Does your child suffer from Anaphylaxis*? Yes No

*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Does your child carry an EpiPen? Yes No

Does your child carry an inhaler? Yes No

**Medical Conditions** (Include any precautions or restrictions on activities.)

| Name of Condition | Effects |
|---|---|
| 1. | |
| 2. | |
| 3. | |

**Medications**: List any medications she is currently taking (or has taken recently). Include dosage schedule and specific instructions for use. Also, please indicate (Yes/No) if minor is allowed to take the medication on her own or if she should be monitored by an advisor. This includes any type of birth control.

| Medication | Purpose | Dosage Schedule | Specific Instructions | Self-Medicate? (Yes/No) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

**Over-the-Counter Medications:** My child has permission to take over-the-counter medications in case of accident or injury. Please check all that she has permission to take:

- ☐ Tylenol/Acetaminophen
- ☐ Aspirin (fever reducer)
- ☐ Ibuprofen (pain/swelling)
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/expectorant
- ☐ Sudafed/decongestant
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Imodium (anti-diarrhea)
- ☐ Dramamine (motion sickness prevention)
- ☐ Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
- ☐ Other: _____
- ☐ Other: _____

**Special considerations or notes regarding over-the-counter medications:**

**Does your child have a Special Medical or Dietary Regiment to be followed?** Yes No
If so, please explain: _____

**Have you ever had any adverse reactions to general anesthetics?** Yes No

If so, please explain: _____

**Any other information not covered in this form that is important that advisors for this trip know:** _____

_____

**Girl Name:** _____ **Date:** _____

*This section is to be completed by a physician after the review of health history with parent/guardian. Parent/Guardian must complete all the information of the Health History to the best of their knowledge and sign before meeting with licensed professional.*

**Medical Examination – Must be completed in detail.**

Height: _____ Weight: _____

B. P.: _____/_____ Hearing: R ___ L ___

Eyes: With Glasses R 20/_____ L 20/___ Without Glasses R 20/____ L 20/____

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

| | | | |
|---|---|---|---|
| _____ Nose | _____ Abdomen | _____ Urinalysis* | Other: _____ |
| _____ Throat | _____ Hernia | _____ HGB* | _____ |
| _____ Teeth | _____ Genitalia | _____ Appearance/Nutrition | _____ |
| _____ Heart | _____ Skin | _____ General Physical State | _____ |
| _____ Lungs | _____ Musculoskeletal | _____ General Emotional State | _____ |

*Girls should have this test if she had not had it since entering puberty.

**Record of Immunization – Must be completed in detail.**

| | Date Series was Completed | Year of Last Booster | | Date Series was Completed | Year of Last Booster |
|---|---|---|---|---|---|
| Hep B | _____ | _____ | Typhoid | _____ | _____ |
| DTap/Tdap | _____ | _____ | Paratyphoid | _____ | _____ |
| DT/Td | _____ | _____ | Cholera | _____ | _____ |
| Hib | _____ | _____ | Yellow Fever | _____ | _____ |
| IPV/OPV | _____ | _____ | Typhus | _____ | _____ |
| PCV7 | _____ | _____ | Rocky Mountain | | |
| MMR | _____ | _____ | Spotted Fever | _____ | _____ |
| Varicella | _____ | _____ | Tuberculin Test: Year last given | _____ | Result _____ |
| | | | | | |
| Other: | | | Not required immunizations, but recommended | | |
| _____ | _____ | _____ | HPV | _____ | _____ |
| _____ | _____ | _____ | Rota | _____ | _____ |
| _____ | _____ | _____ | MCV4/MPSV4 | _____ | _____ |
| _____ | _____ | _____ | Hep A | _____ | _____ |
| _____ | _____ | _____ | TIV/LAIV | _____ | _____ |

Personal and religious beliefs dictate against immunizations: Yes No

**Physician Information**

| **Licensed Physician Name:** (Last, First, Middle Initial) | **Phone Number:** | | |
|---|---|---|---|
| **Address:** | **City:** | **St:** | **Zip:** |

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

**Signature of Licensed Physician:** _____

**State License Number:** _____ **Date:** _____

**HEALTH INFORMATION PRIVACY STATEMENT**

The **Health History and Medical Examination Form for Minors** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

**This Health History and Medical Examination Form for Minors is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.**

**Signature of Parent/Guardian:** _____ **Date:** _____