



Girl and Adult Health History Record

Confidential

Name: _____ Date of Birth: _____ Age: _____

Full Address: _____ Phone: _____

Girl is in the custody of: Mother Only Father Only Both Parents Other _____

Parent/Guardian Name: _____ Day Phone: _____

Address (if different than girl): _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Additional Emergency Contact (individual to act on behalf of person named on Line 1):

Name: _____ Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Physician: _____ Physician's Phone: _____

Medical/Hospital Insurance Carrier: _____ Policy/Group #: _____

Date of last health exam _____ List any medical problems noted _____

Date of last tetanus shot _____

Is participant currently under physician's or psychologist's care? yes no Issue: _____

Special accommodations needed: _____

Allergies (please attach additional sheet if needed):

Item: _____ Reaction: _____ Life threatening: YES NO Next Step: _____

Item: _____ Reaction: _____ Life threatening: YES NO Next Step: _____

Item: _____ Reaction: _____ Life threatening: YES NO Next Step: _____

I _____ (initial) confirm that my child has the knowledge and skills to safely possess and use Epinephrine Auto-Injector.

Has the participant had (if you check any of the items below, please explain. Use additional paper as needed):

- a serious injury requiring medical attention? an illness lasting more than 5 days?
- any prescribed or over-the-counter meds? any restriction concerning physical activities?
- a surgical operation or fracture? any exposure to a contagious disease?
- treatment in hospital or emergency room? other (specify): _____

Illnesses (Chronic or Recurring) & Injuries (check those that apply and give dates of last incident):

- Ear infection _____ Asthma _____ Seizures _____
- Bleeding/clotting disorders _____ Heart defect/disease _____ Diabetes _____
- Hypertension _____ Musculoskeletal Disorders _____ Others (specify) _____
- _____ _____ _____

I _____ (initial) confirm that my child has the knowledge and skills to safely possess and use asthma inhaler.

Other Health Conditions (check those that apply, explain any checked items)

- Bed wetting Sleep disturbances Special dietary regimen Emotional disturbances
- Nosebleeds Menstrual cramps Wears glasses/contact lenses Motion sickness
- Constipation Fainting Sickle cell trait or immune disease Hearing impairment
- Other (specify): _____

This health history is complete and accurate. I know of no reason(s) why my child/I should not participate in activities except as noted. I understand that if the health condition or health insurance information should change, I will notify her Girl Scout leader. In the event I cannot be reached in an emergency, I hereby give permission to the physician indicated above or medical personnel to secure and administer treatment, including hospitalization for my daughter/myself.

Signature of Parent/Guardian: _____ Date: _____
or Adult named on Line 1