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:** _____