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?
☐ any prescribed or over-the-counter meds?
☐ a surgical operation or fracture?
☐ treatment in hospital or emergency room?
☐ an illness lasting more than 5 days?
☐ any restriction concerning physical activities?
☐ any exposure to a contagious disease?
☐ 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 ☐ Mental health
☐ Nosebleeds ☐ Menstrual cramps ☐ Wears glasses/contact lenses ☐ Motion sickness
☐ Constipation ☐ Fainting ☐ Sickle cell trait or immune disease ☐ Hearing impairment
☐ Additional Information: _____

This health history is complete and accurate. I know of no reason(s) why my daughter/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