Girl Health History Record

ALL INFORMATION TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN OF GIRL ANNUALLY

PART I: GIRL RECORD

Girl's Name	School Attending	Birth Date	Troop Number
Address/City/State/Zip		Family E-Mail Address *(For GSNC use only)*	
Mother's Name	Day Time Telephone ( )	Evening Phone ( )	
Father's Name	Day Time Telephone ( )	Evening Phone ( )	

Is your girl/ward disabled? ❐ NO ❐ YES If YES, does she need accommodation? ❐ NO ❐ YES

Do we have your permission for your child/ward to receive emergency medical treatment if needed? ❐ NO ❐ YES

HEALTH INFORMATION PRIVACY STATEMENT

The Girl Health History Record 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 of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment 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 history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.***

Parent/Guardian Signature: **Date:**

I give permission for my daughter to receive treatment for routine medical and/or first aid needs as outlined in the Treatment Protocols and for the administration of prescribed medications. I understand that in the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Northern California to give emergency medical and surgical treatment and hospitalization as necessary for my child and/or dependent minor by a licensed physician pursuant to Section-6910 of the civil Code of California. I know of no reason(s) other than the information indicated on this form, why my daughter/dependent should not participate in prescribed activities.

Parent/Guardian Signature	Date	Telephone Number	Cell Phone Number

PART II: EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN

Name	Day Time Telephone ( )	Evening Phone ( )

PART III: HEALTH INSURANCE INFORMATION

Name of family DENTIST:____Telephone: ( )___________________________________

Name of family PHYSICIAN:____Telephone: ( )___________________________________

Family Medical/Hospital INSURANCE CARRIER: ____________________________POLICY/GROUP NUMBER: __________________________

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) **❐ Check here for no known allergies**

❐Animals___________________ ❐Hay Fever_________________ ❐Medicines/Drugs _____________ ❐Pollen __________________________

❐Food _____________________ ❐Insect Stings_______________ ❐Plants_______________________ ❐Other (specify) __________________

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates) ❐Other Chronic/Recurring Illnesses (specify) _______________

❐Asthma ___________________ ❐Diabetes __________________ ❐Heart Defect/Disease__________ ❐Musculoskeletal Disorder _________

❐Bleeding/Clotting Disorders ___ ❐Ear Infection _______________ ❐Hypertension ________________ ❐Seizures ______________________

Date of last health examination: __________________________ Were any complicating medical problems noted in last health examination? ❐NO ❐YES

If YES, what? ____

Other Health Conditions: (Check those that apply) ❐Other (specify): ____

❐Attention Deficit Disorder (ADD)	❐Down's Syndrome	❐Hearing Impairment	❐Nose Bleeds	❐Wears Glasses/Contacts
❐Bed Wetting	❐Emotional Disturbances	❐Menstrual Cramps	❐Sickle Cell Trait/Disease	❐Special Dietary Regimen
❐Dental Braces	❐Fainting	❐Motion Sickness	❐Sleep Disturbances	❐Visual Impairment

PART V: MEDICATION

Is your girl taking any medications? ❐ NO ❐ YES

If YES, list medication, reason, and possible side effects.

MEDICATION	REASON	POSSIBLE SIDE EFFECTS
____________	____________	_________________________
____________	____________	_________________________
____________	____________	_________________________

Activity Restrictions? ❐ NO ❐ YES

If YES, list restrictions.

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PART VI: IMMUNIZATION HISTORY

❐ The following is my girl's immunization history:

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P .... (Diphtheria, tetanus and pertussis (whooping cough))		
Td		
Measles		
Mumps..................................		
Rubella (German measles)..........		
Polio		
Hbpv		
Tuberculin Test (most recent)....		Result:
Other (Specify):		

❐ I/We have chosen not to immunize my/our girl.

Parent/Guardian Signature Date

Please review this form annually. If there are no changes or just minor adjustments, please mark those, then sign and date the form.

Forms Bank/Health Forms/HH_Girl_Health_History.doc 03/2009

Updated ____________________________________ Date ______________

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Updated ____________________________________ Date ______________