girl scouts of colorado

Girl Health History for Extended Trips

The **Medical Examination** on page 3 is required for all international extended trips and encouraged for all extended trips (3 nights or more). It needs to be completed within the preceding 24 months of the trip.

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	☐	Sleep disturbances
☐	Heart Defects/Disease	☐	Fainting
☐	Asthma	☐	Bed wetting
☐	Ear Infections	☐	Constipation
☐	Musculoskeletal Disorders	☐	Chicken Pox
☐	Convulsions/Epilepsy/Seizures	☐	Measles
☐	Sinusitis (Sinus Infections)	☐	German Measles
☐	Physical Restrictions	☐	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:

Girl Name: _____

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 daughter 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 daughter carry an Epipen? Yes No

Does your daughter carry an inhaler? Yes No

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Medications: List any medications she is currently taken (or has taken in the recent past) including 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 would include any type of birth control.

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

Over-the-Counter Medications: My daughter 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: _____

Permission for Emergency Medical Treatment
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 Colorado to seek treatment for my child/dependent by a licensed physician pursuant. I know of no reason(s) why my daughter/dependent may not participate in prescribed activities except as noted on the Health History form. **If permission is not given, please prepare a signed statement providing the reason, a release of liability, and alternate instructions and attach to this form.**

Health Information Privacy Statement
This form will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. 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 this form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This form is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted.

Signature of Parent/Guardian: _____ Date: _____

Medical Examination

To be completed in detail by a physician after the review of health history with parent/guardian.

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
Hep B	_____	_____
DTap/Tdap	_____	_____
DT/Td	_____	_____
Hib	_____	_____
IPV/OPV	_____	_____
PCV7	_____	_____
MMR	_____	_____
Varicella	_____	_____
Other:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

	Date Series was Completed	Year of Last Booster
Typhoid	_____	_____
Paratyphoid	_____	_____
Cholera	_____	_____
Yellow Fever	_____	_____
Typhus	_____	_____
Rocky Mountain Spotted Fever	_____	_____
Tuberculin Test: Year last given_____ Result _____		
Not required immunizations, but recommended		
HPV	_____	_____
Rota	_____	_____
MCV4/MPSV4	_____	_____
Hep A	_____	_____
TIV/LAIV	_____	_____

Personal and religious beliefs dictate against immunizations: Yes No

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 and physically demanding activities, except as noted.

Signature of Licensed Physician: _____ **State License Number:** _____ **Date:** _____