



Girl Health History

Parents/guardians: complete, sign, and give to the Troop/Group Leader

Troop/Group Leaders: Keep this information in a safe and confidential place. When this girl is no longer a member, please shred document. This form may be used for many years if it is reviewed, updated and signed annually. **This form must be on site during any Girl Scout activity.**

Girl's Name _____ Date of Birth _____
 _____ Last _____ First _____
 Parent/Guardian _____
 Parent/Guardian Home Phone _____ Work Phone _____
 Cell Phone _____ E-mail _____
 Name of family physician _____ Phone _____
 Family medical/hospital insurance carrier _____ Policy or Group No. _____

Part I: Illnesses and injuries (Check those that apply.)

- Ear Infection Bleeding/Clotting Disorders Hypertension Hypotension Asthma
- Hypoglycemia Heart Defect/Disease Seizures Musculoskeletal Disorders
- Diabetes Other (specify) _____

Date of last health examination: _____

Were any complicating medical problems noted in last health examination? _____

Part II: Allergies (Check those that apply and specify nature of allergic reaction.)

- Animals _____ Hay fever _____
- Pollen _____ Food _____
- Medicines/drugs _____ Insect stings _____
- Plants _____ Other (specify) _____

Part III: Other health conditions (Check those that apply.)

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

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P. (Diphtheria; Pertussis (whooping cough); Tetanus)	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella (German measles)	_____	_____
Oral Polio	_____	_____
Hib	_____	_____
Tuberculin test (most recent)	_____	Result _____
Other _____	_____	_____

Girl's Name _____
Last First

Current medications (need to be in original container with dosage). _____

Dietary restrictions _____

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

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 and/or dependent minor by a licensed physician. 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 for emergency medical treatment is not given, please prepare a signed statement providing the reason, a release of liability, and alternate instructions and attach to this form.**

I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

Signature of parent/guardian _____ Date _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____