girl scouts of southern arizona

Girl Health History Record

Girl's Information

name	date of birth	age	troop #
address	city	st	zip
school			
parent/guardian	phone, home	phone, evening	
home address	city	st	zip
business address phone		phone, work	

Emergency Contact & Insurance/Physician

name	relationship	phone	
address	city	st	zip
physician's name		phone	
insurance provider		policy / group #	

Illnesses & Injuries, Chronic or Recurring Illness

Check all that apply.

- ☐ Ear infection
- ☐ Heart defect / disease
- ☐ Other:
- ☐ Bleeding / clotting disorder
- ☐ Musculoskeletal disorder
- ☐ Hypertension
- ☐ Seizure
- ☐ Asthma
- ☐ Diabetes

date of last health exam

- ☐ Yes, complicated medical problems were noted in last health examination.
- ☐ Yes, participant is currently under the care of a physician or psychologist

Since last health exam, participant has had:

- ☐ A serious injury requiring medical attention
- ☐ Any presribed or over-the-counter medication
- ☐ Treatment in a hospital or emergency room
- ☐ An illness lasting more than five days
- ☐ A surgical operation or fracture
- ☐ Any restrictions concerning physical activities

Please explain any "yes" to the above questions, including dates:

Allergies

Check all that apply and specify nature of allergic reaction.

- ☐ Animals:
- ☐ Insect stings:
- ☐ Pollen:
- ☐ Medicine / drugs:
- ☐ Plants:
- ☐ Food:
- ☐ Hay fever:
- ☐ Other:

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Other Health Conditions

Check all that apply.

☐ Bed wetting	☐ Emotional disturbances	☐ Motion sickness	☐ Sickle cell trait or disease
☐ Constipation	☐ Hearing impairment	☐ Sleep disturbances	☐ Special dietary needs
☐ Fainting	☐ Nosebleeds	☐ Menstrual cramps	☐ Wear glasses or contact lenses
☐ Other:			

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Indicate any activities to be encouraged or restricted. Please attach additional documentation as needed.

Signatures

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

parent / guardian signature | date

Emergency Medical Authorization

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while on a Girl Scout activity when parents and guardians cannot be contacted.

I give my consent for emergency medical treatment of my daughter in the emergency room of the nearest hospital and for a certified first aider to provide first aid treatment.

parent / guardian signature

phone | date

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