

# Girl Health History Record

Girl's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Full Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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 parent/guardian):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Girl's 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: \_\_\_\_\_

## Since last health exam, has participant had (If you check any of the items below, please explain. Use additional paper as needed):

- |  |  |
|--|--|
| <input type="checkbox"/> a serious injury requiring medical attention? | <input type="checkbox"/> an illness lasting more than 5 days?            |
| <input type="checkbox"/> any prescribed or over-the-counter meds?      | <input type="checkbox"/> any restriction concerning physical activities? |
| <input type="checkbox"/> a surgical operation or fracture?             | <input type="checkbox"/> any exposure to a contagious disease?           |
| <input type="checkbox"/> treatment in hospital or emergency room?      | <input type="checkbox"/> Other (specify): _____                          |

## Illnesses (Chronic or Recurring) & Injuries (Check those that apply and give dates of last incident):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Ear Infection _____               | <input type="checkbox"/> Asthma _____                    | <input type="checkbox"/> Seizures _____         |
| <input type="checkbox"/> Bleeding/Clotting Disorders _____ | <input type="checkbox"/> Heart Defect/Disease _____      | <input type="checkbox"/> Diabetes _____         |
| <input type="checkbox"/> Hypertension _____                | <input type="checkbox"/> Musculoskeletal Disorders _____ | <input type="checkbox"/> Others (specify) _____ |
| <input type="checkbox"/> _____                             | <input type="checkbox"/> _____                           | <input type="checkbox"/> _____                  |

## Other Health Conditions (Check those that apply, explain any checked items)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Bed Wetting            | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Special Dietary Regimen             | <input type="checkbox"/> Emotional Disturbances |
| <input type="checkbox"/> Nosebleeds             | <input type="checkbox"/> Menstrual Cramps   | <input type="checkbox"/> Wears Glasses/Contact Lenses        | <input type="checkbox"/> Motion Sickness        |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Sickle Cell Trait or Immune Disease | <input type="checkbox"/> Hearing Impairment     |
| <input type="checkbox"/> Other (specify): _____ |   |  |   |

*This health history is complete and accurate. I know of no reason(s), why my daughter should not participate in activities except as noted. I understand that if my child's 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 qualified personnel to secure and administer treatment, including hospitalization for my daughter.*

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Year 2: Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature indicates that this health history has been updated and is complete and accurate.