girl scouts in the heart of pennsylvania

Health History Form - Girl

Personal Information

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip Code _____

Parent/Guardian _____

( ) _____ ( ) _____

Phone Other Phone

If Parent/Guardian cannot be reached, please notify:

Name _____

( ) _____ ( ) _____

Phone Other Phone

Name _____

( ) _____ ( ) _____

Phone Other Phone

Physician Information

Name _____ ( ) _____

Phone

Medical/Hospital Insurance Carrier _____ Policy/Group Number _____

Date of last health exam _____ Are activities restricted? ☐ Yes ☐ No If yes, please explain. _____

Health History

I. Allergies: Check all that apply and elaborate if necessary.

☐	Animals	_____	☐	Plants	_____
☐	Food	_____	☐	Pollen	_____
☐	Insect bites/stings	_____	☐	Medicine	_____
☐	Hay Fever	_____	☐	Other	_____

II. Chronic/Recurring Conditions: Check all that apply.

☐	Asthma/Respiratory Problems	☐	Epilepsy	☐	Seizures
☐	Kidney Disease	☐	Headaches	☐	Constipation
☐	Musculoskeletal Disorders	☐	Fainting	☐	Hearing Impairment
☐	Sickle Cell Trait or Disease	☐	Nosebleeds	☐	Emotional Disturbances
☐	Ear Infections	☐	Bleeding/Clotting Disorders	☐	Diabetes
☐	Dietary Restrictions	☐	Hypertension	☐	Heart Disease
☐	Other				

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III. Check if child wears any of the following:

☐ Contact Lenses ☐ Glasses ☐ Dental Appliance ☐ Other _____

Please List All Current Medications

_____ _____

_____ _____

_____ _____

Are any needed during troop/group activities? ☐ Yes ☐ No – If yes, please list which ones below:

_____ _____

_____ _____

_____ _____

The Following Over the Counter Medicines May Be Given to My Child

Tylenol	☐ Yes	☐ No	Ibuprofen	☐ Yes	☐ No	Benadryl	☐ Yes	☐ No
Antiseptic Ointment	☐ Yes	☐ No	Calamine Lotion	☐ Yes	☐ No	Insect Repellent	☐ Yes	☐ No

TREATMENT AUTHORIZATION

Parent/Guardian Statement: This health history is complete and accurate. I know of no reason(s), other than indicated on this form, why my child should not participate in troop/group activities except as noted. I authorize the Girl Scout adult in charge to consent to medical treatment when either I or my assignee cannot be contacted. I understand every effort will be made to contact me before such action. I assume financial responsibility for emergency care if such care is not covered by GSUSA Activity Accident Insurance.

_____ _____

Signature: Date:

FOR OFFICE USE ONLY	
Date Received:	Initials:

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