Email | Print Form

GIRL HEALTH HISTORY / EMERGENCY MEDICAL AUTHORIZATION FORM A130

To be filled out by parent/guardian

Return Form to: Troop/Group Leader at or before the first meeting. Must be updated yearly or as changes occur.

Child's Name (first, middle initial, last) _____ Troop # _____ SU# _____ Level _____

Birth Date _____ Age _____ School attending _____ State _____ Grade _____

Home address _____ City _____ State _____ Zip _____

Parent or Guardian _____ Phone: Day _____ Cell _____ Evening _____

Home address _____ City _____ State _____ Zip _____

2nd Parent or Guardian _____ Phone: Day _____ Cell _____ Evening _____

Home address _____ City _____ State _____ Zip _____

Child is in the custodial care of ☐ *both parents* ☐ *mother only* ☐ *father only* ☐ *other* _____

Emergency Contact: *If neither parent/guardian is available in an emergency, contact:*

Name: _____ Relationship _____ Phone: Evening _____ Day _____ Cell _____

Name: _____ Relationship _____ Phone: Evening _____ Day _____ Cell _____

Health History: (*Check all that apply and give approximate dates. Use the Continuation Page as necessary*)

☐ ADD/ADHD _____
☐ Arthritis _____
☐ Asthma _____
☐ Athletes Foot _____
☐ Bed Wetting _____
☐ Bleeding/Clotting Disorders _____
☐ Bronchitis _____
☐ Colds/Sore Throats _____
☐ Constipation _____
☐ Convulsions _____
☐ Diabetes _____
☐ Ear Infections _____
☐ Epilepsy _____
☐ Fainting _____
☐ Hay Fever _____
☐ Headaches/Migraines _____
☐ Hearing _____
☐ Heart Defect/Disease _____
☐ Hypertension _____
☐ Kidney Disease _____
☐ Mononucleosis _____
☐ Motion Sickness _____
☐ Muscle Disease/Disorder _____
☐ Nervous System Disorder _____
☐ Sickle Cell Anemia _____ Wears: ☐ Contacts ☐ Glasses
☐ Sinusitis _____
☐ Skeletal Disease/Disorder _____
☐ Skin Conditions _____
☐ Sleep Disturbance/Walking _____
☐ Stomach Upsets _____
☐ Urinary Tract Infections _____
☐ Chicken Pox _____
☐ German Measles _____
☐ Measles _____
☐ Mumps _____
☐ Other _____

Allergies:

☐ Animals _____
Bee/Wasp Stings _____
☐ Plants, Ivy/Oak _____
☐ Drugs _____
☐ Foods _____
☐ Other _____

Are there any special needs or accommodations required? If yes, please explain _____

Are there any known behavioral and/or emotional problems? If yes, explain _____

Ever required any psychiatric counseling or hospitalization? If yes, explain _____

Operations or serious injuries _____

Disability or chronic or recurring illness _____

Activities to be encouraged or limited by her physician? _____

Dietary modifications _____

Has this person menstruated? _____ If not, has she been told about it? _____ If so, is her menstrual history normal? _____

Since her last health exam has your child had ☐ a serious injury requiring medical attention? _____ ☐ an illness lasting longer than one week? _____

☐ an in-patient hospital treatment or the emergency room? _____ ☐ been restricted from participating in any school activities? _____

(Please explain any "YES" answers to the above questions and include dates and/or details. May use the Continuation Page if necessary.)

Immunization History: Are all immunizations up-to-date? ☐ yes ☐ no If no, please state reason _____

(Give immunization date that the child listed above has had. Complete other information as requested.) DTP or DT (Tetanus) Date: _____

Insurance Information: Company _____ Policy Number _____ Policy Holder _____

Company address: _____ City: _____ State _____

Other: Name of Dentist/Orthodontist: _____ Phone _____

Name of Physician _____ Phone _____ Date of last health exam _____

Preferred Medical Facility: _____ Location: _____

Medication Information: Any prescribed medication being taken? ☐ yes ☐ no ☐ Inhaler ☐ Epipen ☐ Other - what, why, when, and dosage?

_____

Current Weight ____ Current Height ____ My child may be given (check all that apply): ☐ Aspirin ☐ Benadryl ☐ Ibuprofen ☐ Neosporin ☐ Tylenol ☐ None

IMPORTANT – THIS SECTION MUST BE COMPLETED

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First Aider or Adult in charge to provide routine health care and administer prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by GSUSA, GSCNC or individual units. Should a medical emergency arise during my child's participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied for trips and camping outside of the normal meeting place.

Signature of Parent/Guardian _____ Date _____

*If for religious reasons you cannot sign this form, then submit a legal waiver, which must be signed for attendance/participation.

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GIRL HEALTH HISTORY / EMERGENCY MEDICAL AUTHORIZATION FORM *Continuation Page*

Use this page to enter any information that would not fit on the previous page.