girl scouts of northern california

October 1, 20_____ to September 30, 20_____

Girl Health History Form with Physical

Please download and save this form before entering the information. You may also choose to print and complete the form manually. Kindly print clearly.

Girl Scout Name: _____ Troop #: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Date of Birth: _____ Date of Last Health Exam: _____

Girl's Physician/Clinic: _____ Phone: _____

Parent/Legal Guardian: _____ Phone: _____

Hospital Insurance Information:

Name of Carrier: _____ Policy #: _____

Insured's Name: _____ Member ID#: _____

Insured's Employer (if insurance is through work): _____ Phone: _____

Others who could be contacted to authorize treatments:

Name: _____ Relationship to Girl: _____ Phone: _____

Name: _____ Relationship to Girl: _____ Phone: _____

PART A
Allergies

Check those that apply. Specify cause and nature of reactions (i.e. Penicillin causes hives.)

Animals _____ Plants/Trees _____ Insect Sting: _____
Hayfever _____ Pollen _____
Other: _____

Food:

Medicine/Drugs:

In case of an allergic reaction, respond by

PART B
Medical History

Check those that apply.

☐ ADD/ADHD	☐ Ear Infection	☐ Mumps
☐ Arthritis	☐ Eating Disorders	☐ Muscle Disease/Disorder
☐ Asthma	☐ Emotional Disturbances	☐ Nervous System Disorder
☐ Anxiety	☐ Epilepsy	☐ Nosebleeds
☐ Athletes Foot	☐ EYES: Contact Lenses	☐ Orthodontic Appliances
☐ Behavioral Changes	☐ EYES: Glasses	☐ Physical Disabilities
☐ Bet Wetting	☐ Fainting	☐ Runny Nose
☐ Bipolar Disorder	☐ German Measles	☐ Seizures
☐ Bleeding/Clotting Disorder	☐ Hay Fever	☐ Sickle Cell Trait or Disease
☐ Bronchitis	☐ Headaches, frequent	☐ Sinusitis
☐ Chicken Pox	☐ Hearing Impairment	☐ Skeletal Disease/Disorder
☐ Concussion	☐ Heart Defect/Disease	☐ Skin Conditions
☐ Constipation	☐ Hepatitis A/B/C	☐ Sleep Disturbance
☐ Convulsions	☐ Hypertension	☐ Sleep Walking
☐ Cough	☐ Kidney Disease	☐ Sore Throat
☐ COVID-19	☐ Measles	☐ Special Dietary Regiment
☐ Depression	☐ Menstrual Complications	☐ Stomach Upsets
☐ Diabetes	☐ Migraines	☐ Urinary Tract Infection
☐ Diarrhea	☐ Mononucleosis	☐ Visual Impairments
☐ Down's Syndrome	☐ Motion Sickness	

☐ Other:

Please explain. Indicate any information useful to the adult in charge in relation to any of the health conditions chosen in Part B. Indicate any activity to be encouraged or restricted.

Dietary Needs/Restrictions:

PART C Immunization & Disease History	**REQUIRED:** Please complete			
	Immunization	Year Primary Series Completed	Year of Last Booster	Has had Disease YES or NO
	Chicken Pox			
	COVID-19			
	D.T.P.			
	Diphtheria			
	Hepatitis B			
	Hib *Haemophilus influenzae B*			
	Measles			
	Mumps			
	Oral Polio			
	Pertussis (whooping cough)			
	Rubella (German Measles)			
	Td (tetanus/diptheria)			
	Tetanus			
	Tuberculin Test Result (most recent)			
	Other:			

MEDICATIONS	Listed are all prescribed medication(s) that my child will routinely take. Attach a separate list if necessary		
	Medication	Dosage	How often?
Please initial below if applicable			
↓	Enter Name of Girl Scout: _____ will self-administer the following medication(s).		
*	☐ Bronchial Inhaler		
*	☐ Diabetic Medication		
*	☐ Epi-pen		
*	☐ Other		

Over-The-Counter Medication(s):
Over-the-counter medications will be used to treat routine illness per treatment protocols. Acetaminophen is used in place of aspirin.

She can have ☐ Pain medications ☐ Cough syrup ☐ Antibiotic ointment ☐ Fever reducer
☐ Digestive relief ☐ Other: _____

She CANNOT have: _____

Health Information Privacy Statement
The Girl Health History Form is for health care concerns at the specified meeting or event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific meeting or event. Minimal necessary information may be shared with event staff/volunteer(s) in order to provide adequate participant safety and health care. The health history record will be retained by Girl Scouts of Northern California, the sponsoring council, or GSUSA until it is destroyed. All forms/ records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

Transportation Release: I authorize transportation for my child by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of my child. It is my expressed intention to hold Girl Scouts of Northern California harmless for any and all injuries, death or damages arising from or any way related to any such transportation.

Consent to Treat: In the event of an emergency, every effort will be made to contact an emergency contact. I hereby give authorization to Girl Scouts of Northern California to seek treatment for my child by a licensed physician. I hereby give permission to the physician selected to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/ or surgery should my child's medical emergency require this treatment.

The information disclosed on this form may be released to Volunteer/Staff responsible for this meeting or activity, including, but not limited to troop/group leaders, drivers, medical personnel, etc.

Parent's/Legal Guardian's Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all planned trip activities except as noted by the examining physician or me. By allowing my child to participate in Girl Scout activities and events: a) I acknowledge that an inherent risk of exposure to COVID-19 exists for any in-person activity, including meetings, activities, events, and trips; and b) I am voluntarily assuming all risks related to exposure to COVID-19 and agree not to hold Girl Scouts of Northern California, or any of its directors, employees, agents or volunteers, liable for any illness or injury. I have read the above procedures for handling the health history form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature of Parent/Legal Guardian	**Relationship To Girl Scout**	**Date**
Print Name of Parent/Legal Guardian	**Phone**	**Email Address:**

Record of Health Examination: To be completed within 24 months of event attendance by a licensed physician – MD. Physician's Assistant or Nurse Practitioner acting under the supervision of a licensed MD.

I have examined the above applicant within the past 24 months. Date of exam: _____
In my opinion, the above applicant's condition ☐ Does ☐ Does NOT preclude her participation in an active program.

Activities to be limited: _____

The applicant is under the care of a physician for the following condition: _____

Current treatment (including medication): _____

Height: _____ Weight: _____ Blood Pressure: _____

Name of Physician: _____

Signature of Physician: _____

Doctor's Office Address: _____

Phone: _____

Date Signed: _____