

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
	Bed 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 <i>Haemophilus influenzae B</i>			
	Measles			
	Mumps			
	Oral Polio			
	Pertussis (whooping cough)			
	Rubella (German Measles)			
	Td (tetanus/diphtheria)			
	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: I hereby give permission to the physician selected [by the trip coordinator] to order x-rays, routine tests and treatment for the health of my child, in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the first aider/trip coordinator to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above. I also give my consent for my child to be tested for the COVID-19 virus while participating at a trip or overnight event by the event First Aider, using an over-the-counter test, should my child become ill or exhibit COVID symptoms. If permission is not given for COVID-19 testing, I agree to pick up my child as soon as possible after the First Aider has contacted me.

The information disclosed on this form may be released to Volunteer/Staff responsible for this 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 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: