



Girl Health History Record with Physical

PARENT: Complete form through Part VII - Parent Consent section on the back.

PHYSICIAN: Complete statement on back of form.

PART I: GIRL RECORD

Girl's Name - Last, First, Middle Initial		Birth Date - MM/DD/YYYY	Age
Home Address		City/State/Zip	Family E-Mail Address (For GSNC use only)
Parent/Guardian Name	Day Time Telephone ()	Evening Phone ()	Cell Phone ()
Parent/Guardian Name	Day Time Telephone ()	Evening Phone ()	Cell Phone ()

PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name	Day Time Telephone ()	Evening Phone ()
Home Address	City/State/Zip	Relationship to Girl

PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: _____ Telephone: () _____

Address of family PHYSICIAN: _____ City / State / Zip _____

Family Medical/Hospital INSURANCE CARRIER: _____ POLICY/GROUP NUMBER: _____

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.? Yes No

If yes, what ID number does your child use? _____ What is the HMO main phone number for emergencies? () _____

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) **Check here for no known allergies**

Animals _____ Hay Fever _____ Medicines/Drugs _____

Pollen _____ Food _____ Insect Stings _____

Plants/Poison Oak _____ Other (specify) _____

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

Asthma _____ Diabetes _____ Heart Defect/Disease _____

Musculoskeletal Disorder _____ Bleeding/Clotting Disorders _____ Ear Infection _____

Hypertension _____ Seizures/Convulsions _____ Mononucleosis _____

Skin Disease/MRSA _____ Other (specify) _____

Childhood Diseases: (Check those that apply and give appropriate dates)

Chicken Pox _____ Measles _____ German Measles _____

Mumps _____ Other (specify) _____

Other Health Conditions: (Check those that apply)

Attention Deficit Disorder (ADD) Down's Syndrome Hearing Impairment Nose Bleeds

Wears Glasses/Contacts Bed Wetting Emotional Disturbances Menstrual Cramps

Sickle Cell Trait/Disease Special Dietary Regimen Dental Braces Fainting

Motion Sickness Sleep Disturbances Visual Impairment

List any current physical, mental or psychological health conditions requiring medical treatment, special restrictions or considerations: _____

List any dietary restrictions or special considerations: _____

List any previous medical treatments, operations or serious injuries, provide dates: _____

PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you **DO NOT** want your daughter to receive: _____

Is your daughter taking any medications? NO YES
If YES, list medication, dosage, and possible side effects.

MEDICATION	DOSAGE	POSSIBLE SIDE EFFECTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the child's name, address, dosage and frequency. Please label with girl's name and dosage any over-the-counter drugs - anti-histamines, vitamins, etc.

PART VI: IMMUNIZATION HISTORY - REQUIRED		
Vaccines	Year of Basic Immunization	Year of Last Booster
DPT	Diphtheria, Pertussis (Whooping Cough), Tetanus	
TD	Tetanus, Diphtheria	
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Rubella (German measles, 3-day measles)		
Tuberculin test given _____ (most recent)		
Hepatitis B		
Other:		

List any condition that would limit full activity and in what way: _____

Additional comments from parents/guardians: _____

PART VII: PARENT CONSENT

This health history is correct as far as I know, and my daughter has permission to engage in all prescribed activities, except as noted by me and the physician. My daughter is in good health. I give permission for my daughter to receive treatment for routine medical and/or first aid needs, as outlined in the Treatment Protocols and for the administration of prescribed medications. In the event I cannot be reached in an emergency, I give my permission for my daughter _____, to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action.

*All medications being taken are listed on the front of this form.

Parent/Guardian Signature: _____

Date: _____

PART VIII: RECORD OF HEALTH EXAMINATION

**To be completed within 24 months of camp attendance by a
 LICENSED PHYSICIAN – MD, PHYSICIAN’S ASSISTANT OR
 A NURSE PRACTITIONER ACTING UNDER THE SUPERVISION OF A LICENSED MD**

I have examined the above applicant within the past 24 months. DATE EXAMINED _____

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 conditions: _____

Current treatment (including medications): _____

Height _____ Weight _____ Blood Pressure _____

Name of Physician _____

Signature of Physician _____

Phone (_____) _____

Date Signed _____

Doctor’s Office Stamp or Address



PERSONS AUTHORIZED TO PICK-UP MY CHILD

NAME _____ **CAMP** _____

SESSION _____ **PROGRAM** _____ **DATE** _____

The following persons are authorized to pick-up my child from camp or from the camp and /or bus un-loading. I understand that these people, including myself, will be asked to show identification to the staff member at checkout. I understand that if someone who is not on this list attempts to pick up my child, the camp or Girl Scout office will contact me or the emergency contact listed on the front of health form for authorization. I understand that Girl Scouts of Northern California will not release my daughter to anyone who is not authorized by me as the parent/legal guardian.

Contact phone number: _____

PARENT NAME	PARENT SIGNATURE	DATE
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A. BEFORE CAMP:
Please list the authorized pick up people in this section (including parents):

1. _____
2. _____
3. _____
4. _____
5. _____

B. AT CHECK OUT:
Authorized Persons Sign Here
At Time of Pick Up (leave blank until pick up)

1. _____
2. _____
3. _____
4. _____
5. _____