

CONFIDENTIAL

Girl or Adult Health History Record

This record will be retained by the adult leader for one year and will accompany the adult in charge at all meetings and other activities (i.e. field trips, camping, SU events, etc.) All information on this form will be kept confidential and stored in a place where others may not view the information contained on this form.

LEADER: _____

Full Legal Name _____

Nickname _____

Troop # _____

Health Conditions: Past and present (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating Disorders (Anorexia, Bulimia, etc.) | <input type="checkbox"/> Kidney/Bladder Illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional/Mental health disorder | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eyesight Impairment | <input type="checkbox"/> Musculoskeletal Disorders |
| <input type="checkbox"/> Attention Disorder | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Sinusitis (Sinus Infections) |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Convulsions/Epilepsy/Seizures | <input type="checkbox"/> Heart Defects/Disease | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hernia | <input type="checkbox"/> Had surgery or hospitalized in the last 5 years |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension/High Blood Pressure | <input type="checkbox"/> Seizure(s) |
| <input type="checkbox"/> Diseases of the Ear or Ear Infections | <input type="checkbox"/> Intestinal Disorders/Constipation | <input type="checkbox"/> Other _____ |

Date of last health examination: _____ Please explain in detail any items checked above: _____

Does your child have any restrictions concerning physical activities? Yes No

Explain: _____

Allergies

- | | | | |
|---------------------|----------------------------|--------------------|--------------------------------|
| 1. _____
Allergy | _____
Reaction/Severity | _____
Treatment | _____
Date of Last Reaction |
| 2. _____
Allergy | _____
Reaction/Severity | _____
Treatment | _____
Date of Last Reaction |

Does she/you suffer from Anaphylaxis? Yes No

(A severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.)

• Does she/you carry an Epipen? Yes No • Does she/you carry an inhaler? Yes No

• Are her/your immunizations up to date, including Tetanus? Yes No

Prescription Medication

List any medications including dosage schedule and specific instructions for use. All prescriptions must be in the original container with appropriate label.

- | | | | |
|------------------------|------------------|-----------------|--------------------------------|
| 1. _____
Medication | _____
Purpose | _____
Dosage | _____
Specific Instructions |
| 2. _____
Medication | _____
Purpose | _____
Dosage | _____
Specific Instructions |
| 3. _____
Medication | _____
Purpose | _____
Dosage | _____
Specific Instructions |

Over-The-Counter Medications

Parent/Guardian of Minors: My Daughter has permission to take the following medications in case of accident, injury, or minor illness.

- | | | |
|--|---|--|
| <input type="checkbox"/> Tylenol / Acetaminophen | <input type="checkbox"/> Imodium (anti-diarrhea) | <input type="checkbox"/> Skin Ointments |
| <input type="checkbox"/> Cough Medicine | <input type="checkbox"/> Ibuprofen (pain/swelling) | (in case of rash, antibacterial, athlete's foot, etc.) |
| <input type="checkbox"/> Pepto Bismol | <input type="checkbox"/> Benadryl / Antihistamine | <input type="checkbox"/> Tums / Antacid |
| <input type="checkbox"/> Sudafed / Decongestant | <input type="checkbox"/> Dramamine (motion sickness prevention) | |

Other _____

Special considerations or notes _____

My child has the following dietary restrictions _____

Signatures *Handwritten Signature Required*

For Custodial Parents/Guardians: I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities, except as noted above. This Health History Form is complete and accurate. I understand that if the health condition or information should change, I will notify her Girl Scout Leader.

Signature of Custodial Parent/Guardian _____ Today's Date _____

For Adults: This Health History Form is correct, and I am able to participate in all prescribed activities, except as noted above.

Emergency Contact: Name _____ Phone(s) _____

Relationship _____ Signature _____ Today's Date _____