



Girl Scout Council of the Nation's Capital  
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**A130**

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

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 # \_\_\_\_\_ 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. Attach additional sheets as necessary)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> ADD/ADHD _____                    | <input type="checkbox"/> Epilepsy _____                | <input type="checkbox"/> Sickle Cell Anemia _____  | <b>Allergies:</b>                              |
| <input type="checkbox"/> Arthritis _____                   | <input type="checkbox"/> Fainting _____                | <input type="checkbox"/> Sinusitis _____   | <input type="checkbox"/> Animals _____         |
| <input type="checkbox"/> Asthma _____                      | <input type="checkbox"/> Hay Fever _____               | <input type="checkbox"/> Skeletal disease/disorder _____   | <input type="checkbox"/> Bee/wasp stings _____ |
| <input type="checkbox"/> Athletes Foot _____               | <input type="checkbox"/> Headaches; Migraines _____    | <input type="checkbox"/> Skin Conditions _____   | <input type="checkbox"/> Plants, ivy/oak _____ |
| <input type="checkbox"/> Bed Wetting _____                 | <input type="checkbox"/> Hearing _____                 | <input type="checkbox"/> Sleep Disturbance/ Walking _____  |  |
| <input type="checkbox"/> Bleeding/clotting disorders _____ | <input type="checkbox"/> Heart defect/disease _____    | <input type="checkbox"/> Stomach upsets _____  | <input type="checkbox"/> Drugs _____           |
| <input type="checkbox"/> Bronchitis _____                  | <input type="checkbox"/> Hypertension _____            | <input type="checkbox"/> Urinary Tract Infections _____  |  |
| <input type="checkbox"/> Frequent Colds/Sore Throats _____ | <input type="checkbox"/> Kidney Disease _____          | Wears: <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> Foods _____ |  |
| <input type="checkbox"/> Constipation _____                | <input type="checkbox"/> Mononucleosis _____           | <input type="checkbox"/> Chicken pox _____   |  |
| <input type="checkbox"/> Convulsions _____                 | <input type="checkbox"/> Motion Sickness _____         | <input type="checkbox"/> German measles _____  | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Diabetes _____                    | <input type="checkbox"/> Muscle disease/disorder _____ | <input type="checkbox"/> Measles _____   |  |
| <input type="checkbox"/> Ear Infections _____              | <input type="checkbox"/> Nervous system _____          | <input type="checkbox"/> Mumps _____   |  |

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 back of form if necessary.)

**Immunization History:** Are all immunizations up-to-date?  Yes  No If no, please state reason \_\_\_\_\_

(Give date of immunization 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 examination \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_ Location: \_\_\_\_\_

**Medication Information:** Any prescribed medication being taken?  No  Yes -  Inhaler  Epipen Other- what, why, when, and dosage? \_\_\_\_\_

Current Weight \_\_\_\_\_ Current Height \_\_\_\_\_ My child may be given (check all that apply):  Aspirin  Benadryl  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 (in ink) \_\_\_\_\_ Date \_\_\_\_\_

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