girl scouts of central texas

Girl Scouts of Central Texas

# Girl or Adult Health History Record

Both pages must be completed & signed by the custodial parent/guardian of girls; ***or*** by adult members for themselves. This record will be retained by the adult leader for one year and accompany the adult in charge at all meetings and other activities (i.e. field trips, camping, SU events, etc.). This form will be shredded after a new form is received. If the individual listed on the form leaves the troop, this form will be immediately shredded. 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. *For adults: complete the information that is necessary for the Girl Scout troop or event.*

Full Legal Name:_____ Nickname: _____ Troop #: _____

DOB: _____ Age: _____ ❒ Girl ❒ Adult

Address: _____

Custodial Parent/Guardian if Under 18: _____ Best Phone #: _____

Address (if different than girl's address): _____

Emergency Contact: _____ Best Phone #: _____

## Health Conditions: Past and Present [Check all that apply]

| | | | |
|---|---|---|---|
| | Arthritis | | Hernia |
| | Asthma | | Hypertension/High Blood Pressure |
| | Bedwetting | | Intestinal Disorders/Constipation |
| | Bleeding disorder | | Kidney/bladder illness |
| | Convulsions/Epilepsy/Seizures | | Menstrual cramps |
| | Diabetes | | Musculoskeletal Disorders |
| | Diseases of the Ear or Ear Infections | | Mental/psychological disorder |
| | Eating Disorders (Anorexia, Bulimia, etc.) | | Nosebleeds |
| | Eyesight Impairment | | Sinusitis (Sinus Infections) |
| | Fainting/dizzy spells | | Sleep Disturbances |
| | Headaches/Migraines | | Speech Impairment |
| | Hearing Impairment | | Had surgery or hospitalized in the last 5 years |
| | Heart Defects/Disease | | Currently under doctor or psychologist's care |
| | Other: | | |

Date of last health examination:

Were any complicating medical problems noted in the last health exam? ❒ Yes ❒ No

Please explain in detail any items checked above:

Since last health exam, has participant had:

| | | | |
|---|---|---|---|
| A serious injury requiring medical attention? ❒ Yes ❒ No | | Treatment in a hospital or emergency room? ❒ Yes ❒ No | |
| A surgical procedure or fracture? ❒ Yes ❒ No | | Any exposure to a contagious disease? ❒ Yes ❒ No | |

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

## Allergies

| Allergies | 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**

## Physician/Dentist, Hospital, and Insurance Information

Physician's name: _____ Phone #: _____

Medical Insurance Carrier name: _____ Insurance number: _____

Preferred hospital: _____

Dentist's name: _____ Phone #: _____

Dental Insurance Carrier name: _____ Insurance number: _____

Handwritten Signature Required

*Attach picture of individual here.*

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# Girl or Adult Health History Record

**Full Legal Name:**_____ **Nickname:** _____ **DOB:** _____

**Record of Immunization [Must be completed in detail)]**

| Immunization | Date Series Completed | Year of Last Booster | Immunization | Date Series Completed | Year of Last Booster |
|---|---|---|---|---|---|
| Hepatitis B | | | Hepatitis A | | |
| Diphtheria, Tetanus, Pertussis (DTap/Tdap) | | | Inactivated Poliovirus (IPV) | | |
| Measles, Mumps, Rubella MMR) | | | Influenza | | |
| Rotavirus (RV) | | | Varicella | | |
| *Haemophilus influenzae* (type b Hib) | | | Meningococcal (MCV) | | |
| Pneumococcal (PCV) | | | Human Papillomavirus (HPV) | | |
| Tuberculin Test: Result Date | | | **Other:** | | |

**PRESCRIPTION MEDICATION**

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

| 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 or injury:

| | | | |
|---|---|---|---|
| | Tylenol/Acetaminophen | | Pepto Bismol |
| | Aspirin (fever reducer) | | Imodium (anti-diarrhea) |
| | Ibuprofen (pain/swelling) | | Dramamine (motion sickness prevention) |
| | Benadryl/Antihistamine | | Tums/antacid |
| | Robitussin/expectorant | | Sudafed/decongestant |
| | Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.) | | |

Other:

Special considerations or notes:

I have reviewed the GSCTX policy on administering medication to a minor and submitted the appropriate permission forms to the adult in charge. ❒ **Yes** ❒ **No** ❒ **N/A** - My child is not currently taking any prescribed or over the counter medications.

My child has the following dietary restrictions:

**SIGNATURE(S)**

**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.

_____ _____

**Signature of Custodial Parent or Guardian** **Today's Date**

**For Adults:** This health history is correct, and I am able to participate in all prescribed activities except as noted.

_____ _____

**Signature of Adult** **Today's Date**