girl scouts

Girl Scouts of Western Washington

Girl or Adult Health History Record

To be completed & signed by parent/ guardian of girls *or* by adult members for themselves.

Name: _____ Date of Birth: _____ Age: _____ ☐ Girl ☐ Adult

Address: _____

Parent/Guardian if Under 18: _____ Phone: _____

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

Doctor's Name: _____ Phone: _____

Emergency Contact: _____ 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 your child suffer from Anaphylaxis?* Yes ☐ No ☐

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

Does she carry an Epipen? Yes ☐ No ☐ **Does she carry an inhaler? Yes ☐ No ☐**

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:**		

Medications and Dietary Restrictions

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 GSWW 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 OTC medications.

My child has the following dietary restrictions:

For 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 parent/guardian: _____ **Date:** _____

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

Signature of adult: _____ **Date:** _____