



Girl Scouts

# GIRL HEALTH HISTORY RECORD

This health history is to be completed and signed by the Parents/guardians of girls.

Name	Date of Birth	Age
Address	Troop No.	
Parent/Guardian	Phone ( )	
Home Address		
Business Address	Phone ( )	
Emergency Contact Name	Relationship	
Address	Phone ( )	
Name of Family Physician	Phone ( )	
Family Insurance Carrier	Policy No.	

### Part I: Illnesses and injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness

- Ear Infection     Bleeding/Clotting Disorders     Hypertension     Asthma     Other (specify) \_\_\_\_\_  
 Heart Defect/Disease     Musculoskeletal Disorders     Seizures     Diabetes    \_\_\_\_\_

Date of last health examination: \_\_\_\_\_

Were any complicating medical problems noted in last examination? \_\_\_\_\_

Is participant currently under the care of a physician or psychologist? \_\_\_\_\_

Since last health exam, has participant had:

- |  |  |
|--|--|
| A serious injury requiring medical attention? _____  | An illness lasting more than five days? _____          |
| Any prescribed or over-the-counter medication? _____ | A surgical operation or fracture? _____                |
| Treatment in a hospital or emergency room? _____     | Any restrictions concerning physical activities? _____ |
| Any exposure to a contagious disease? _____          | Other? _____   |

Please explain any "yes" answers to the above questions. Include dates: \_\_\_\_\_

### Part II: Allergies (check those that apply and specify nature of allergic reaction.)

- Animals \_\_\_\_\_     Hay Fever \_\_\_\_\_  
 Pollen \_\_\_\_\_     Food \_\_\_\_\_  
 Medicines/Drugs \_\_\_\_\_     Insect Stings \_\_\_\_\_  
 Plants \_\_\_\_\_     Other(Specify) \_\_\_\_\_

### Part III: Other health conditions (check those that apply)

- Bed Wetting     Emotional disturbances  
 Constipation     Fainting  
 Menstrual Cramps     Hearing impairment  
 Motion sickness     Sickle cell trait or disease  
 Nosebleeds     Special dietary regimen  
 Sleep disturbances     Wears glasses or contacts  
 Other (specify) \_\_\_\_\_

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

\_\_\_\_\_  
\_\_\_\_\_

### Part IV: Immunization History

Immunization	Year primary series completed	Year of last booster
D.T.P.	_____	_____
Diphtheria	_____	_____
Pertussis (whooping cough)	_____	_____
Tetanus	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
(German Measles)	_____	_____
Oral Polio	_____	_____
Hbpv	_____	_____
Tuberculin test (most recent)	_____	Result _____
Other	_____	_____

My daughter \_\_\_\_\_ has permission to participate in

\_\_\_\_\_ On \_\_\_\_\_

I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in the prescribed activities as noted. I grant permission for pictures taken of my daughter to be used to promote the Girl Scout program.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_