

Girl or Adult Health History Record

To be completed and 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]

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

Date of last health examination: _____	Were any complicating medical problems noted in the last health exam? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please explain in detail any items checked above:

Since last health exam, has participant had:

A serious injury requiring medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment in a hospital or emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No
A surgical procedure or fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any exposure to a contagious disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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/injury:

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

Other:

Special consideration or notes:

I have reviewed the Girl Scouts of Western Washington 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:** _____