GIRL SCOUT MEDICAL INFORMATION

Girl Scouts of San Jacinto Council

(THIS FORM MAY BE PHOTOCOPIED WHEN COMPLETED. PRINT CLEARLY, USE BLACK INK.)

Girl's Name _____ Troop/Group # _____ Phone ( ) _____

Home Address _____ City _____ State _____ Zip _____

Date of Birth _____ Date of last Health Exam _____

Girl's Physician/Clinic _____ Phone ( ) _____

Parent/Legal Guardian _____ Phone ( ) _____ Cell Phone ( ) _____

HOSPITAL INSURANCE INFORMATION **Attach photocopy of insurance card.**

Name of Carrier _____ Policy # _____

Insured's name _____ Member ID# _____

Company name if insured through employer _____ Phone: ( ) _____

Others who could be contacted to authorize treatments:

Name _____ Day( ) _____ Evn( ) _____ Relationship _____

Name _____ Day( ) _____ Evn( ) _____ Relationship _____

PART I

Allergies (Check those that apply. Specify cause and nature of reactions - e.g. penicillin causes hives.)

__Animals __Plants __Food __ Medicine/Drugs _____

__Hayfever __Pollen __Insect Sting

__Other: _____

In case of an allergic reaction, respond by _____

_____

PART II

Health Conditions (Check those that apply.)

Chronic or reoccurring illness: _____

__Asthma	__Musculoskeletal Disorders	__Kidney Disease
__Diabetes	__Heart Disease/Defects	__Hypertension
__Seizures	__Bleeding/Clotting Disorder	__Ear Infection

__Other: _____

IN THE LAST YEAR: (ANSWER YES OR NO)

Complicating medical problems/operations? _____ Serious injury/illness requiring medical care? _____

Explain: _____

_____

SPECIFIC INSTRUCTIONS / ONGOING TREATMENTS: _____

_____

PART III

Other Health Conditions (Check those that apply.)

__Sleep disturbances	__Motion sickness	__Constipation/diarrhea	__Bedwetting
__Hepatitis A / B / C (circle one)	__Menstrual complications	__Sickle cell trait or disease	__ADHD / ADD
__Emotional disturbances	__Hearing impairment	__Special dietary regiment	__Fainting
__Physical disabilities	__Frequent headaches	__Wears contact lenses/glasses	__Nosebleeds
__Orthodontic appliances	__Eating disorders		

__Other (specify) _____

Please explain. Indicate any information useful to the adult in charge in relation to any of the above health conditions.

Indicate any activity to be encouraged or restricted _____

Dietary Needs / Restrictions: _____

GIRL SCOUT INSURANCE CARRIER: MUTUAL OF OMAHA For confirmation, contact Girl Scouts of San Jacinto Council 713-292-0300 or 1-800-392-4340

PART IV

Immunization/Disease History (Please complete or attach a copy of this child's Immunization Record)			
Immunization	**Year Primary Series Completed**	**Year of Last Booster**	**Has had Disease**
D.T.P.			
Diphtheria			
Pertussis (whooping cough)			
Tetanus			
Td (tetanus/diptheria)			
Measles			
Mumps			
Rubella (German Measles)			
Chicken Pox			
Oral Polio			
Hib			
Hepatitis B			
Tuberculin Test Result (most recent)			
Other			

Listed are medication(s) my child will routinely take with the supervision of the Leader/First Aider. (Attach a list if necessary.)		
Medication:	Dosage:	How Often:

Over the Counter Medication(s):

She can have: _____

She **cannot** have: _____

Parent's/Legal Guardian's Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all planned trip activities except as noted by the examining physician or me.

TRANSPORTATION RELEASE: I authorize transportation for my child by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of my child. It is my expressed intention to hold Girl Scouts of San Jacinto Council harmless for any and all injuries, death or damages arising from or in any way related to any such transportation.

CONSENT TO TREAT: I hereby give permission to the physician selected [by the trip coordinator] to order X-rays, routine tests and treatment for the health of my child, in the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the first aider/trip coordinator to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child as named above.

The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to troop/group leaders, drivers, medical personnel, etc.

My signature confirms that the above information is correct to the best of my knowledge and that I am authorized to execute the information form and release.

_____

Signature of Parent/Legal Guardian **Full Name of Child** **Relationship to Child** **Date**

_____ **Day ( )** _____ **Evn ( )** _____ **Cell ( )** _____

Print Name of Parent/Legal Guardian

_____

Address **City** **State** **Zip**