MEMBER HEALTH HISTORY RECORD

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

I, the parent or legal guardian (with custody) of ______________________________, age______, do hereby consent to the release of the information contained in this form to Girl Scout personnel supervising my daughter and to medical and emergency personnel in case of an accident, injury or other medical emergency situation. This consent shall remain in effect until my daughter (i) attains eighteen (18) years of age, (ii) this consent is terminated by me in writing, or (iii) my daughter is no longer a Girl Scout.

Signed______________________________ Date__________________

Print Name______________________________

Name of Child______________________________ Date of Birth__________________

Address____

Home Phone (___)__________ Work Phone (___)__________ Cell Phone (___)__________

Name of family health care provider____________________ Phone (___)__________

Part 1: Illnesses and Injuries
(check those that apply)

- □ Ear infection
- □ Bleeding/Clotting Disorders
- □ Diabetes
- □ Asthma
- □ Seizures
- □ Other (specify)____________________
- □ Heart Defect/Disease
- □ Musculoskeletal Disorders
- □ Hypotension
- □ Hypertension
- □ Hypoglycemia

Part 2: Other health conditions
(check those that apply)

- □ Bed Wetting
- □ Constipation
- □ Menstrual cramps
- □ Motion Sickness
- □ Nosebleeds
- □ Sleep disturbances
- □ Headaches/migraines
- □ Other (specify)____________________
- □ Emotional disturbances
- □ Fainting
- □ Hearing impairment
- □ Sickle cell trait or disease
- □ Special dietary regime
- □ Wears glasses/contact lenses

Date of last Tetanus Booster shot: ____________ Date of last health examination______________

Part 3: Allergies (check those that apply and specify nature of allergic reaction)

- □ Animals____________________
- □ Pollen____________________
- □ Medicine/Drugs____________________
- □ Plants____________________
- □ Hay Fever____________________
- □ Food(s)____________________
- □ Insect Stings____________________
- □ Other (specify)____________________

An explanation of any items checked would be useful to the adult in charge in order to provide your daughter with the best experience possible:

MEDICINE PERMISSION SLIP

I give ________________________________ my permission to give the following over-the-counter medications, inhalers, or prescription medication to my daughter, ________________________, if necessary during a program event.

Please fill out all sections that apply:

Medication	Dosage (amount & frequency)

My daughter uses inhalers for respiratory ailments as follows. She has my permission to keep this with her.

Medication	Frequency

My daughter needs an allergic reaction kit for ______________________________ allergy.

This is to be given to the leader with instructions.

My daughter is on the following prescription medications:

Medication	Frequency	Reason for Taking

Please Note: Prescription medication to be administered during a program event must be accompanied by a dated and signed physician's note which indicates dosage and frequency. The girl is not allowed to keep any medication with her. It must be turned into the leader.

________________________________ ____________________

Signature of Parent/Guardian Date