Girl Scout Council of Colonial Coast
Health History - Girl

Health History: The more complete information you provide, the better we are able to work with your child to ensure she receives the care she needs.

Please type or write clearly and legibly.

Girl Name: (Last, First, Middle Initial)	**Date of Birth:** (XX/XX/XXXX)		
Address:	**City:**	**St:**	**Zip:**
Parent or Guardian:	**Phone:**	**Alternate Phone:**	
Parent or Guardian:	**Phone:**	**Alternate Phone:**	

Emergency Contact Information (parent/guardian):

Emergency Contact:	**Relationship:**
Phone:	**Alternate Phone:**

Health Insurance Information (Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply and explain in detail checked answers:

	Diabetes		Sleep disturbances
	Heart Defects/Disease		Fainting
	Asthma or Breathing Problems		Bed wetting
	Ear Infections		Constipation
	Musculoskeletal Disorders		Chicken Pox
	Convulsions/Epilepsy/Seizures		Measles
	Sinusitis (Sinus Infections)		German Measles
	Disabilities		Mumps
	Kidney/bladder illness or disease		Rheumatic Fever
	Mental/psychological disorder/behavior problems		Tuberculosis
	Hypertension		Special Dietary Regime
	Arthritis		Eating Disorders (Anorexia, Bulimia, etc.)
	Nosebleeds		Headaches/Migraines
	Has begun menstruation		Had surgery or hospitalized in the last 5 years
	Menstrual cramps		Currently under doctor’s care
	Bleeding disorder		Emotional – separation anxiety

	Motion sickness		Developmental problems
	Hearing impairment		Wears glasses or contact lenses
	Sickle cell trait or disease		Serious injuries
	Activities to be restricted		Other:
	Swimming Ability: (Please Check one) ☐ Non-Swimmer ☐ Beginner Swimmer ☐ Advanced Swimmer		
Please explain in detail all checked answers marked above:			

Girl Name:

Allergies: Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Does your daughter suffer from Anaphylaxis? Yes No

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

Does your daughter carry an Epipen? Yes No

Does your daughter carry an inhaler? Yes No

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Medications: List any medications she is currently taken (or has taken in the recent past) including dosage schedule and specific instructions for use. Also, please indicate (Yes/No) if minor is allowed to take the medication on her own or if she should be monitored by an advisor. This would include any type of birth control.

Medication	Purpose	Dosage Schedule	Specific Instructions	Self-Medicate? (Yes/No)
1.				
2.				
3.				
4.				
5.				

Over-the-Counter Medications: My daughter has permission to take over-the-counter medications in case of accident or injury. Please check all that she has permission to take:

Tylenol/Acetaminophen

Ibuprofen/Advil (pain/swelling)

Benadryl/Antihistamine

Robitussin/expectorant

Sudafed/decongestant

Pepto Bismol

Tums/antacid

Imodium (anti-diarrhea)

Dramamine (motion sickness pr

Skin Ointments (in case of rash,

Anti-bacterial, athlete's foot, etc.)

Swimmers' Ear or alcohol/vinegar solution

Other:

Special considerations regarding over-the-cou medications:

Does your child have a Special Medical or Dietary Regiment to be followed? Yes No

If so, please explain:

Has your child ever had any adverse reaction to general anesthetics? Yes No

If so, please explain:

Any other information not covered in this form that is important that advisors for this trip know:

Girl Name: **Date:**

Record of Immunization – Must be completed in detail.

Immunization History	Year Primary Series Complete	Year of Last Booster
Diphtheria,Tetanus, Pertussis (DTP, DTaP)		
Dipthteria Tetanus (DT or Td (given after 7 years of age)		
Poliomyelitis (IPV, OPV)		
Haemophilus influenza (Type B)		
Pneumococcal (PCV conjugate)		
Measles, Mumps, Rubella (MMR)		
Measles (Rubeola)		
Rubella		
Mumps		
Hepatitis B Vaccine (HBV)		
Varicella Vaccine		
Other		

Personal and religious beliefs dictate against immunizations: Yes No

Physician Information

Licensed Physician Name: (Last, First, Middle Initial)	**Phone Number:**		
Address:	**City:**	**St:**	**Zip:**

PARENT STATEMENT & PRIVACY STATEMENT: This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except noted. All health records will be handled by staff/volunteers whose job includes processing or using this information for the

benefit of the participant. This information will be held in limited access by the troop leader/health care supervisor for the event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care.

PARENT AUTHORIZATION: If my child needs medical treatment by the camp/event nurse, first-aider, or other personnel, I give my permission for her to be attended for care. Furthermore, I hereby give permission for the administration of anesthesia and performance of emergency surgery, if deemed advisable in the opinion of physicians.

I have read the above information and agree to the release of any records necessary for treatment, referral, billing or insurance purposes

This Health History Form is complete and accurate. My daughter has permission to engage in all activities, except as noted by me.

Signature of Parent/Guardian: **Date:**

Year Two Signature: ____ **Date:**

DESTINATION HEALTH NOTES for first aider use only

DAILY MEDICATION RECORD

Medication	Dose	Time	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Medication	Dose	Time	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

FIRST AIDER NOTES – document any first aid and PRN meds here

Date/Time **Notes (condition and treatment)** **Initial**