girl scouts of san jacinto

United Way

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	☐ 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:

(indicate girl's name) will self-administer.
☐ Epi-pen
☐ Bronchial inhaler
☐ Diabetic medication
Please specify dosage and frequency:

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**

Print Name of Parent/Legal Guardian **Day** _____ **Evn** _____ **Cell** _____

Address **City** **State** **ZIP**