

# GIRL HEALTH FORM

(To be given to the first aider at each event and carried by the leader on field trips.)

Girl's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parent or Guardian Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Person to Notify in Emergency \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Medical Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

## HEALTH HISTORY (Check and Date)

Asthma \_\_\_\_\_  Diabetes \_\_\_\_\_  Hay Fever \_\_\_\_\_  Measles \_\_\_\_\_  
 Bleeding Disorder \_\_\_\_\_  Drugs \_\_\_\_\_  Heart Disease \_\_\_\_\_  Mumps \_\_\_\_\_  
 Chicken Pox \_\_\_\_\_  Ear Infection \_\_\_\_\_  Hypertension \_\_\_\_\_  Musculoskeletal  
 Convulsion/Seizure \_\_\_\_\_  Other (Specify) \_\_\_\_\_ Disorder \_\_\_\_\_

Other Diseases/Illnesses/Surgeries \_\_\_\_\_  
 Additional medical information \_\_\_\_\_  
 Date of last physical examination \_\_\_\_\_  
 Special dietary information \_\_\_\_\_

## ALLERGIES (Check those that apply and specify nature of allergic reaction)

Animals \_\_\_\_\_  Medicine/Drugs \_\_\_\_\_  
 Food \_\_\_\_\_  Plants \_\_\_\_\_  
 Insect Stings \_\_\_\_\_  Pollen \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_

## IMMUNIZATIONS (Dates)

Year Primary Series Completed

Year of Last Booster

D.T.P.	_____	_____
Diphtheria	_____	_____
Measles	_____	_____
Mumps	_____	_____
Oral Polio	_____	_____
Rubella	_____	_____
Tetanus	_____	_____
Whooping Cough	_____	_____
Other	_____	_____
Tuberculin Test	Type _____	_____
	Year Last Given _____	_____
	Result _____	_____

## OTHER HEALTH CONSIDERATIONS

\_\_\_\_\_ Bedwetting \_\_\_\_\_ Fainting \_\_\_\_\_ Hearing Impairment \_\_\_\_\_ Sleep Walker  
 \_\_\_\_\_ Braces/Retainers \_\_\_\_\_ Frequent Headaches \_\_\_\_\_ Menstruation \_\_\_\_\_ Other  
 \_\_\_\_\_ Constipation \_\_\_\_\_ Glasses/Contacts \_\_\_\_\_ Nosebleeds

Specific activities to be encouraged \_\_\_\_\_

Specific activities to be restricted \_\_\_\_\_

Please attach a list of other information which would be helpful to ensure your daughter has a safe and healthy experience.

This health history is correct and my daughter has permission to engage in all prescribed activities, except as noted.

**All medications are kept and dispensed by the First Aider. Each medication (prescription and non-prescription) must be in the original container.**

I give permission for my daughter to take the following medication (prescription and over-the-counter): \_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

**NOTE:** For any Girl Scout trip of more than **three** nights, obtain a Physical Health form from your Neighborhood Manager, which must be completed and signed by a licensed physician within the preceding 24 months. (See *Safety-Wise*, page 12.)