



# Girl Health History Record with Physical

**PARENT:** Complete form through Part VIII - Health Information Privacy Statement section on the back.

**PHYSICIAN:** Complete Part IX - Record of Health Examination on back of form.

## PART I: GIRL RECORD

Girl's Name - Last, First, Middle Initial		Birth Date - MM/DD/YYYY	Age
Home Address		City/State/Zip	Family E-Mail Address (For GSNC use only)
Parent/Guardian Name	Day Time Telephone ( )	Evening Phone ( )	Cell Phone ( )
Parent/Guardian Name	Day Time Telephone ( )	Evening Phone ( )	Cell Phone ( )

## PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name	Day Time Telephone ( )	Evening Phone ( )
Home Address	City/State/Zip	Relationship to Girl

## PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Address of family PHYSICIAN: \_\_\_\_\_ City / State / Zip \_\_\_\_\_

Family Medical/Hospital INSURANCE CARRIER: \_\_\_\_\_ POLICY/GROUP NUMBER: \_\_\_\_\_

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.?  Yes  No

If yes, what ID number does your child use? \_\_\_\_\_ What is the HMO main phone number for emergencies? ( ) \_\_\_\_\_

## PART IV: ALLERGIES/ILLNESSES/INJURIES

**Allergic Reaction:** (Check those that apply and specify nature of allergic reaction)  Check here for no known allergies

Animals \_\_\_\_\_  Hay Fever \_\_\_\_\_  Medicines/Drugs \_\_\_\_\_

Pollen \_\_\_\_\_  Food \_\_\_\_\_  Insect Stings \_\_\_\_\_

Plants/Poison Oak \_\_\_\_\_  Other (specify) \_\_\_\_\_

**Chronic or Recurring Illnesses:** (Check those that apply and give appropriate dates)

Asthma \_\_\_\_\_  Diabetes \_\_\_\_\_  Heart Defect/Disease \_\_\_\_\_

Musculoskeletal Disorder \_\_\_\_\_  Bleeding/Clotting Disorders \_\_\_\_\_  Ear Infection \_\_\_\_\_

Hypertension \_\_\_\_\_  Seizures/Convulsions \_\_\_\_\_  Mononucleosis \_\_\_\_\_

Skin Disease/MRSA \_\_\_\_\_  Other (specify) \_\_\_\_\_

**Childhood Diseases:** (Check those that apply and give appropriate dates)

Chicken Pox \_\_\_\_\_  Measles \_\_\_\_\_  German Measles \_\_\_\_\_

Mumps \_\_\_\_\_  Other (specify) \_\_\_\_\_

**Other Health Conditions:** (Check those that apply)

Attention Deficit Disorder (ADD)  Down's Syndrome  Hearing Impairment  Nose Bleeds

Wears Glasses/Contacts  Bed Wetting  Emotional Disturbances  Menstrual Cramps

Sickle Cell Trait/Disease  Special Dietary Regimen  Dental Braces  Fainting

Motion Sickness  Sleep Disturbances  Visual Impairment

List any current physical, mental or psychological health conditions requiring medical treatment, special restrictions or considerations: \_\_\_\_\_

List any dietary restrictions or special considerations: \_\_\_\_\_

List any previous medical treatments, operations or serious injuries, provide dates: \_\_\_\_\_

## PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you **DO NOT** want your daughter to receive: \_\_\_\_\_

Is your daughter taking any medications?  NO  YES  
If YES, list medication, dosage, and possible side effects.

MEDICATION	DOSAGE	POSSIBLE SIDE EFFECTS

**NOTE:** We cannot administer medication that is not in its original container, labeled by the pharmacy with the child's name, address, dosage and frequency. Please label with girl's name and dosage any over-the-counter drugs - anti-histamines, vitamins, etc.

PART VI: IMMUNIZATION HISTORY - REQUIRED			
Vaccines		Year of Basic Immunization	Year of Last Booster
DPT	Diphtheria, Pertussis (Whooping Cough), Tetanus		
TD	Tetanus, Diphtheria		
	Tetanus		
	Oral Polio (Sabin)* TOPV		
	Injectable Polio (Salk)		
	Measles (hard measles, red measles, Rubeola)		
	Rubella (German measles, 3-day measles)		
	Tuberculin test given _____ (most recent)		
	Hepatitis B		
	Other:		

List any condition that would limit full activity and in what way: \_\_\_\_\_

Additional comments from parents/guardians: \_\_\_\_\_

**PART VII: PARENT CONSENT**

I give permission for my daughter to receive treatment for routine medical and/or first aid needs as outlined in the Treatment Protocols and for the administration of prescribed medications. I understand that in the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Northern California to give emergency medical and surgical treatment and hospitalization as necessary for my child and/or dependent minor by a licensed physician pursuant to Section-6910 of the civil Code of California. I know of no reason(s) other than the information indicated on this form, why my daughter/dependent should not participate in prescribed activities.

\*All medications being taken are listed on the front of this form.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PART VIII: HEALTH INFORMATION PRIVACY STATEMENT**

The Girl Health History Record is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. ***I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.***

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PART IX: RECORD OF HEALTH EXAMINATION**

**To be completed within 24 months of camp attendance by a  
 LICENSED PHYSICIAN – MD, PHYSICIAN’S ASSISTANT OR  
 A NURSE PRACTITIONER ACTING UNDER THE SUPERVISION OF A LICENSED MD**

I have examined the above applicant within the past 24 months. DATE EXAMINED \_\_\_\_\_

In my opinion, the above applicant’s condition  DOES  DOES NOT preclude her participation in an active program. Activities to be limited: \_\_\_\_\_

The applicant is under the care of a physician for the following conditions: \_\_\_\_\_

Current treatment (including medications): \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Name of Physician \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Date Signed \_\_\_\_\_

Doctor’s Office Stamp or Address