girl scouts western pennsylvania

Girl Health History Form

Completed Date:_____
Troop/Group #: _____
Received By: _____
Received Date:_____

GENERAL INFORMATION

Girl's Name _____ Birth Date ____/____/____

Address _____
Street City State ZIP Code

Parent/Guardian (1) Name _____

E-mail _____ Phone _____ Alt. Phone _____

Parent/Guardian (2) Name _____

E-mail _____ Phone _____ Alt. Phone _____

Emergency Contact (Other than Parent) _____

Relationship _____ Phone _____ Alt. Phone _____

Custodial Care ❑ Mother ❑ Father ❑ Both ❑ Other If other, please describe: _____

DROP OFF AND PICK UP INFORMATION

Indicate in the space below the name of any person, including yourself, who is allowed to drop off and/or pick up your daughter at any Girl Scouting activity, including troop meetings, programs, camp, etc.

Name	Relationship	Drop Off	Pick Up	Both
		❑	❑	❑
		❑	❑	❑
		❑	❑	❑
		❑	❑	❑

INSURANCE INFORMATION

Carrier Name _____ ID Number _____

Member Services Phone _____ Group Number _____

Address _____
Street City State ZIP Code

Primary Care Physician _____ Primary Care Physician Phone _____

HEALTH CONDITIONS

Allergy	Reaction	Treatment	Date of Last Reaction?

Indicate in the space below any medical conditions (e.g., asthma, diabetes) that your daughter has.

Is there a specific dietary regiment to follow? (If Yes, please provide details below.) ❑ Yes ❑ No

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RECORD OF IMMUNIZATION

Date of last Tetanus vaccine ____/____/____

Select **one** of the following:

☐ I attest that all of the attendee's immunizations, as required for school, are up to date.

☐ Girl member has not received immunizations. Note: Please contact CustomerCare@gswpa.org to obtain and complete an immunization waiver. The waiver is required for participation.

MEDICATIONS

A qualified Health Care Professional (RN, LPN, DMD, or MD) or a PA Medication Administration certified approved volunteer may administer medications to participants. Arrangements between parents/caregivers and GSWPA Approved Volunteer for all medications dispensed must include:

1. Prescription and over-the-counter medications must be provided in their original container.
2. Prescription medications must contain the physician prescribed orders, including instructions.
3. Both prescription and over-the-counter medications **must be given to the Approved Volunteer or First Aider/Health Care Professional.**
4. Some Life threatening conditions will require medications to be carried and secured by the participant, girl or adult, and are approved for carrying in first aid kits. These include: Epi-pens needed for insect stings or serious food allergies, asthma inhalers, and items needed for diabetic and seizure emergencies.

Prescription Medication:

In the space below, please list any prescription medication that your daughter is required to take, including any self-administered emergency medication such as an Epinephrine injector or rescue inhaler.

Medication	Purpose	Self-Administer?
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

Over-the-Counter Medication:

In the list below, please select any over-the-counter medication that your daughter is **NOT** permitted to take.

❑ Ibuprofen	❑ Calamine Lotion	❑ Liquid Tears	❑ Anti-fungal Cream
❑ Aloe Vera	❑ Cough Drops	❑ Menstrual Cramp Relief	❑ Antacid
❑ Bacitracin (i.e. Neosporin)	❑ Dramamine	❑ Expectorant	❑ Acetaminophen
❑ Antihistamine	❑ Antidiarrheal	❑ Decongestant	❑ Other _____

SIGNATURE

Please select the checkbox and sign and date this form:

☐ **Permission to Provide Necessary Treatment or Emergency Care**: I hereby give my permission to medical personnel selected by Girl Scouts Western Pennsylvania to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by Girl Scouts Western Pennsylvania to secure and administer treatment, including hospitalization for the person named above. This health history form is complete to the best of my knowledge, and the person herein described has permission to engage in all program activities, except as noted. This completed form may be photocopied.

☐ **Permission to Self-Administer Medication**: I confirm that my daughter has the knowledge and skills to safely have readily available (carry or possess outside of the regular supervision of the troop leader/first aider) and self-administer the indicated emergency medication as medically necessary at Girl Scout activities. The troop leader/first aider will be notified if they have to use their medication.

_____ ____/____/____

Parent/Guardian Signature Date