

# Girl Scouts of Eastern South Carolina Health History Form for Girls

**Health History:** Girl Scout Councils require an annual health history form to be completed and signed by one parent/guardian for every Girl Scout and filed with the Troop Co-Leader.

*Please type or write clearly and legibly.*

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

**Emergency Contact Information (parent/guardian):**

<b>Emergency Contact:</b>	<b>Relationship:</b>
<b>Phone:</b>	<b>Alternate Phone:</b>

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

<b>Policy Holder's Name:</b>	<b>Policy Number:</b>
<b>Insurance Company Name:</b>	<b>Group Number:</b>
<b>Insurance Company Address:</b>	<b>Insurance Company Phone:</b>

**Check all that apply and explain in detail checked answers:**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Heart Defects/Disease	<input type="checkbox"/> Fainting
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Constipation
<input type="checkbox"/> Musculoskeletal Disorders	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Convulsions/Epilepsy/Seizures	<input type="checkbox"/> Measles
<input type="checkbox"/> Sinusitis (Sinus Infections)	<input type="checkbox"/> German Measles
<input type="checkbox"/> Physical Restrictions	<input type="checkbox"/> Mumps
<input type="checkbox"/> Kidney/bladder illness	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eating Disorders (Anorexia, Bulimia, etc.)
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Headaches/Migraines
<input type="checkbox"/> Has begun menstruation	<input type="checkbox"/> Had surgery or hospitalized in the last 5 years
<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Currently under doctor's care
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Emotional – Separation Anxiety
<input type="checkbox"/> Other:	
<b>Please explain in detail all checked answers marked above:</b>	

**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.			

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.	

**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.				

**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

Aspirin (fever reducer)

Ibuprofen (pain/swelling)

Benadryl/Antihistamine

Imodium (anti-diarrhea)

Dramamine (motion sickness prevention)

Robitussin/expectorant

Sudafed/decongestant

Pepto Bismol

Tums/antacid

Skin Ointments (in case of rash, antibacterial)

Other: \_\_\_\_

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

If so, please explain: \_\_\_\_\_

**Have you ever had any adverse reactions 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:  
\_\_\_\_\_

**This Health History Form for Girls is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.**

**Signature of Parent/Guardian:** \_\_\_\_\_

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

