girl scouts of greater atlanta

20__- 20__

MINOR & ADULT HEALTH HISTORY RECORD

- This health history is to be completed annually and signed by parents/guardians of minor members.
- Adult volunteers should sign and carry their own health history form.
- The information should be reviewed by a parent/guardian or adult member before every trip to ensure the information has not changed.
- The troop leader and troop adult trained in first aid should ensure that the information on this form remains confidential.
- This form is to be kept with the troop/group records. Out-of-date forms should be securely shredded.

Name:______________________________ Date of Birth:______________ Phone #: ________________

Address:____

City:______________________________ State:________ Zip:__________ Troop/Group #: ____________

PART I: PARENT/CAREGIVER INFORMATION AND RELEASE

The above Girl Scout is under the custodial care of:

_____ Both Parents _____ Parent 1 only _____Parent 2 only _____ Caregiver(s) (specify) ________________

Parent 1/Caregiver Name:____

Address (if different than girl):____

Phone (day): ________________________ Phone (evening):________________________

Cell Phone:________________________Email:____

Parent 2/Caregiver Name: ____

Address (if different than girl):____

Phone (day):________________________ Phone (evening):________________________

Cell Phone:________________________Email:____

PART II: EMERGENCY CONTACT AND RELEASE INFORMATION

In the event that I cannot be reached in an emergency, the following are authorized to act in my behalf:

Name:____________________________________ Relationship to Girl: ____________________

Cell Phone:________________________ Other Phone:________________________

Name:____________________________________ Relationship to Girl:____________________

Cell Phone:________________________ Other Phone:________________________

PART III: HEALTH CARE INFORMATION:

Physician's Name:______________________________________ Phone:______________________

Dentist's Name:____ Phone:______________________

Is the girl covered by family medical/hospital insurance? ❑ Yes ❑ No

If so, carrier or plan name:____________________________ Policy or Group #:____________________

Name of insured:__________________________________ Relationship to girl: ____________________

Girl Scouts of Greater Atlanta Emergency Phone Number: 470-273-9952

MEDICAL HISTORY (check those that apply)				
❑ Asthma Provoked by: ______________ ❑ Has Prescribed Inhaler	❑ Diabetes ❑ Epilepsy	❑ Fainting ❑ Lactose Intolerant ❑ Medical Tags/Devices	❑ Nosebleeds ❑ Seizures ❑ Skin Condition	❑ Hearing Impairment ❑ Vision Impairment ❑ Wears Contact Lenses
Additional health information including **disabilities and/or special needs** (medical, physical, emotional, etc...) Please Specify:				

IMMUNIZATION HISTORY (check those that apply)	
❑ Tetanus (within past 10 years) Date: __________________	❑ Immunization Records Are Up-To-Date ❑ N/A

ALLERGY HISTORY (check those that apply)				
❑ Animals ❑ Chlorine (pool)	❑ Hay Fever ❑ Other __________	❑ Insect Stings _______________	❑ Plants/Pollen _____________	❑ Medicine/Drugs _____________________
FOOD: Please list all that we should be aware of. Indicate if **Intolerant (I) or Allergic (A).** Ex. Strawberries **A** , Milk **I**				
❑ Corn ______________ ❑ Dairy ______________ ❑ Eggs ______________ ❑ Fish ______________ ❑ Food Coloring _________	❑ Gluten/Wheat ___________ ❑ Peanuts ______________ ❑ Shellfish ______________ ❑ Soy ______________ ❑ Tree nuts ______________	Other Food Allergies Aware Of: ❑ Fruits/Veggies:		
❑ Inhaler or Epinephrine Used (will add to Provided Prescription Form)	❑ **Dietary special needs** _________________			
If any allergy box was checked, please indicate what the reaction is. Such as: strawberries/rash, milk/cramps, etc.				

Use this space to include any necessary information:

PART V: EMERGENCY MEDICAL AUTHORIZATION: In the event of an emergency, every effort will be made to contact a parent/caregiver or emergency contact. I hereby give authorization to Girl Scouts of Greater Atlanta to seek treatment for my child and/or dependent minor by a licensed physician. I know of no reason(s) why my girl may not participate in prescribed activities except as noted on this Health History Form. If permission for emergency medical treatment is not given, I will prepare a signed statement providing the reason, a release of liability, and alternate instructions and attach to this form.

Signature of Parent/Caregiver:____Date: ____________________

Signature of Parent/Caregiver:____Date: ____________________

❑ **I do not consent to the care or treatment set forth herein. Describe in detail what is/is not allowed/permitted:**

Girl Scouts of Greater Atlanta Emergency Phone Number: 888-644-0511