# 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.*

|  |  |
| --- | --- |
| **Name of Minor:** (Last, First, Middle Initial)Click here to enter text. | **Date of Birth:** (XX/XX/XXXX)Click here to enter text. |
| **Address:**Click here to enter text. | **City:**Click here to enter text. | **St:**Click here to enter text. | **Zip:**Click here to enter text. |
| **Parent or Guardian:**Click here to enter text. | **Phone:**Click here to enter text. | **Alternate Phone:**Click here to enter text. |
| **Parent or Guardian:**Click here to enter text. | **Phone:**Click here to enter text. | **Alternate Phone:**Click here to enter text. |

## Emergency Contact Information (parent/guardian):

|  |  |
| --- | --- |
| **Emergency Contact:**Click here to enter text. | **Relationship:**Click here to enter text. |
| **Phone:**Click here to enter text. | **Alternate Phone:**Click here to enter text. |

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

|  |  |
| --- | --- |
| **Policy Holder's Name:**Click here to enter text. | **Policy Number:**Click here to enter text. |
| **Insurance Company Name:**Click here to enter text. | **Group Number:**Click here to enter text. |
| **Insurance Company Address:**Click here to enter text. | **Insurance Company Phone:**Click here to enter text. |

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





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

## 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.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

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.Click here to enter text. | Click here to enter text. |
| 2.Click here to enter text. | Click here to enter text. |

**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.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2.Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**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

[ ] Robitussin/expectorant

[ ] Sudafed/decongestant

[ ] Pepto Bismol

[ ] Tums/antacid

[ ] Imodium (anti-diarrhea)

[ ] Dramamine (motion sickness prevention)

[ ] 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: Click here to enter text.

## Have you ever had any adverse reactions to general anesthetics? Yes[ ]  No[ ]

If so, please explain: Click here to enter text.

Any other information not covered in this form that is important that advisors for this trip know:

 Click here to enter text.

**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. By typing my name in the box below I am offering my digital signature in lieu of my handwritten signature. I understand that my digital signature carries the same legal bindings as my handwritten signature.**

## Signature of Parent/Guardian:Click here to enter text. Date: Click here to enter text.