



Girl Scouts of Southeastern Michigan

# Girl Health Information Form

## Purpose of this Form

This form contains information regarding allergies and dispensing medication to girl members and is to assist in providing appropriate care. This form should be kept in the troop leader's/advisor's troop records and should not be returned to GSSEM.

## Family Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Parent/Guardian 1 Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Parent/Guardian 2 Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Physician Information

Name of Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_  
My daughter will need the following reasonable accommodations to participate in troop meetings:  
\_\_\_\_\_  
\_\_\_\_\_

## Allergy Information

My daughter is allergic to the following **foods**:

---

---

My daughter is allergic to the following **medications**:

---

---

Signs to look for in case of an allergic reaction:

---

---

If my daughter has an allergic reaction, leaders should do the following:

---

---

---

## In Case of Emergency

In case of emergency, if the parent/guardian cannot be reached, the Leader will notify the following individual(s), who will notify the parent/guardian:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Permission to Dispense Medication

Only to be used by leaders when medication needs to be dispensed to a minor during a field trip or troop meeting.

**PLEASE NOTE:** All prescribed and over-the-counter medications must be in their original containers with the original dosage or prescribed directions on the container. Pills and/or vitamins will not be allowed in a baggie or pre-counted in a pill box. Include things such as allergy and menstrual cramp relief medications. If a prescription does not have your child's name as the designated patient, the medication will not be administered. Over-the-counter or prescription medications will be collected by the adult chaperone/First Aider who will be responsible for dispensing the medication. The only exceptions will be EpiPens and inhalers, which should be listed below and carried by the girl. Medication will not be dispensed without a parent/guardian signature.

My Child takes the medications listed below on a regular basis:

(Include such things as allergy and menstrual cramp relief medications. If a prescription does not have your child's name as the designated patient, we cannot administer the medication)

<u>Medication Name</u>	<u>Prescription/Non-Pres.</u>	<u>Dosage Amount &amp; Time</u>	<u>Possible Side Effects</u>
A: _____			
B: _____			
C: _____			

My child has my permission to take the over-the-counter medications indicated below as deemed necessary by the event First Aider/health supervisor:

Acetaminophen (i.e. Tylenol, Anacin II)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ibuprofen (i.e. Advil, Motrin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Throat Lozenges	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Antibiotic Ointment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Rinse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Caladryl/Benedryl	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tums	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hydrocortisone Cream	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Parent Approval

By signing below, I authorize that all of the information included in this form is correct.

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

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_