girl scouts
heart of new jersey

Girl Health History Record

Girls are required to have a current Health History Record on file for all troop meetings and trips. One copy should travel with the troop/group, the other should remain with the troop/group's at-home emergency contact.

Girl's Name: | Birth Date: | SU# | Troop #

Girl's Address: | City: | State: | Zip:

Girl's Phone #: | Girl's School:

Parent/Guardian 1 Name: | Parent/Guardian 1 Phone #:

Parent/Guardian 2 Name: | Parent/Guardian 2 Phone #:

Troop Leader Name: | Troop Leader Phone #:

EMERGENCY CONTACTS OTHER THAN PARENT/GUARDIAN

Name: | Phone #: | Relation to Girl:

Name: | Phone #: | Relation to Girl:

Name of Physician: | Physician Phone #:

Name of Dentist: | Dentist Phone #:

Family Insurance Carrier: | Policy/Group #:

Name of Primary Insured:

PART I: ILLNESS OR INJURIES

☐ Asthma ☐ Bleeding/Clotting Disorder ☐ Bones/Joints Conditions ☐ Convulsions ☐ Diabetes ☐ Ear Infection

☐ Epilepsy ☐ Hypertension ☐ Kidney Disease ☐ Lung Disease ☐ Other:

Date of Last Health Exam: | Were any complicated medical problems noted? ◯ Yes ◯ No

If yes, please explain:

PART II: ALLERGIES (check all that apply and list treatment)

☐ Animals ☐ Pollen ☐ Food

☐ Plants ☐ Hay Fever ☐ Insects

☐ Medicine/Drugs ☐ Other

PART III: OTHER HEALTH CONDITIONS (check all that apply

☐ ADD ☐ Sleep Disturbances ☐ Hearing Impairment ☐ Vision Impairment ☐ Bed Wetting ☐ Emotional Disturbances

☐ ADHD ☐ Dental Braces ☐ Hearing Aid ☐ Glasses/Contacts ☐ Sickle Cell ☐ Nosebleeds

☐ Autism ☐ Motion Sickness ☐ Fainting ☐ Obesity ☐ Special Diet ☐ Down's Syndrome

☐ Other:

PART IV: IMMUNIZATION HISTORY

IMMUNIZATION	DATE PRIMARY SERIES COMPLETED	DATE OF LAST BOOSTER
Tdap (Tetanus/Diptheria/Pertussis)		
Td (Tetanus/Diptheria)		
MMR (Measles/Mumps/Rubella)		
Chicken Pox		
Oral Polio		
HbPV (Haemophilus b Polysaccharide)		
Tuberculin	Date of Last Test:	Result:
Other:		

☐ I choose not to disclose any immunization history and therefore take full responsibility if any illness occurs as a result of attending a Girl Scout event and not providing immunization history. I also understand that my daughter cannot attend events that require immunization records, unless presented at that time. By checking this box and signing below, I demonstrate that I understand my risk and responsibility.

ACTIVITY RESTRICTIONS:

EMERGENCY MEDICAL CARE Medical Release and Waiver

I hereby give permission to the medical personnel selected by GSHNJ to provide routine health care; to administer medication; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician to secure and administer treatment, including hospitalization, and to order injections and /or anesthesia and /or surgery for the child named above.

INSURANCE INFORMATION – Insurance Release and Waiver

- I hereby give permission for GSHNJ to release to the hospital/doctor/pharmacy/etc. the necessary insurance information knowing every effort will be made to contact me prior to admission.
- This health history is correct as far as I know.
- This completed form may be printed/photocopied.
- The person herein described has my permission to engage in all prescribed activities except as noted on this health history form.

I know of no reasons, other than those indicated on this form, why my child should not participate in general Girl Scout activities.

Form Completed By: Completion Date:

In witness whereof, this release and waiver has been carefully read and the contents of this document are understood by the undersigned. This release and waiver shall be effective for all activities throughout the membership year of the completion date (October 1-September 30). The undersigned freely executes this release and waiver on the date shown below.

Parent/Guardian Name: Parent/Guardian Signature: Date: