girl scouts of the colonial coast

Girl/Adult Health History Form

This form is to be completed and signed by a Girl Scout's caregiver or the adult participant.

This participant is a ☐ girl ☐ adult. ☐ Immunization History is attached. ☐ All immunizations are up-to-date.

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Phone _____ Gender _____

Address _____ City _____ State _____ Zip _____

Primary Caregiver Name _____ Phone _____

Secondary Caregiver Name _____ Phone _____

Medical Insurance Carrier _____ Policy/Group # _____

Primary Physician Name _____ Phone _____

Allergies (list allergies and specify nature of allergic reaction):

Illness and diseases – Chronic or recurring:

Other Health Conditions:

Permission to give to participant:

☐ Tylenol/Acetaminophen ☐ Tums/Antacid ☐ Sudafed/Decongestant ☐ Swimmer's Ear or Alcohol/Vinegar Solution

☐ Benadryl/Antihistamine ☐ Advil/Ibuprofen ☐ Robitussin/Expectorant ☐ None

Medications: "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. If the participant needs to take any medication during the activity, fill in the information below. All medication (both over-the-counter and prescription) must be in its original container with original pharmacy label or manufacturer's label. Medication will not be administered unless accompanied by this form. Provide enough medication for the duration of the activity only. Attach additional sheets if necessary.

Name of medication	Date started	Reason for taking it	Time it is given	Dose to be given	How it is given

Participant Statement: I certify that to the best of my knowledge this health history is complete and accurate. I know of no reasons(s) other than the information indicated on this form, why I/my daughter should not participate in prescribed activities except noted here.

Privacy Statement: All health records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. This information will be held in limited access by the troop leader/healthcare supervisor of the event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate safety and healthcare. I have read the above information and agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Caregiver Authorization: If my child needs medical treatment, I authorize the adult in charge, should it be necessary, to secure the service of a doctor at my expense. I give my permission for her to be attended for care. I am aware that I will be contacted in the case of an emergency.

Caregiver/Adult Participant Signature **Date**