

## Girl Health History

### PART I: Illness and Injuries (check all that apply)

Chronic or recurring illness: \_\_\_\_\_

Date of your daughter's last examination \_\_\_\_\_

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Musculoskeletal Disorder   | <input type="checkbox"/> Heart Disease/Defect  |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Lyme Disease  | <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Other (specify) _____ |

Yes      No

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Were any complicating medical problems noted in the last examination? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your daughter currently under a physician's care?                  |

Since the last health exam, has she had:

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | serious injury requiring medical attention?                          |
| <input type="checkbox"/> | <input type="checkbox"/> | illness lasting more than five days?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | surgical operation or fracture?                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | medication prescribed by a physician to be taken on a regular basis? |
| <input type="checkbox"/> | <input type="checkbox"/> | treatment in a hospital as an in-patient or in the emergency room?   |
| <input type="checkbox"/> | <input type="checkbox"/> | any restrictions concerning physical activity?                       |

Please explain any "yes" answers to the above questions. Include dates: \_\_\_\_\_

If you have indicated a "yes" reply to any of the above questions, a written statement from your daughter's physician granting permission to participate in strenuous activity such as water sports; horseback riding; skiing; hiking; or non-contact sports such as track, tennis, or gymnastics is required.

### PART II: Allergies (check all that apply) Specify causal agent and nature of reactions, e.g. penicillin causes hives.

- |  |   |
|--|---|
| <input type="checkbox"/> Animals _____       | <input type="checkbox"/> Medicine/drugs _____ |
| <input type="checkbox"/> Food _____          | <input type="checkbox"/> Plants _____         |
| <input type="checkbox"/> Hay fever _____     | <input type="checkbox"/> Pollen _____         |
| <input type="checkbox"/> Insect stings _____ | <input type="checkbox"/> Other _____          |
- What actions should be taken? \_\_\_\_\_

### PART III: Other health conditions (check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> hearing impairment           | <input type="checkbox"/> menstrual complications | <input type="checkbox"/> orthodontic appliances       |
| <input type="checkbox"/> sickle cell trait or disease | <input type="checkbox"/> emotional disturbances  | <input type="checkbox"/> bedwetting                   |
| <input type="checkbox"/> fainting                     | <input type="checkbox"/> motion sickness         | <input type="checkbox"/> wears contact lenses/glasses |
| <input type="checkbox"/> sleep disturbances           | <input type="checkbox"/> special dietary regimen | <input type="checkbox"/> nosebleeds                   |
| <input type="checkbox"/> other (specify) _____        |  |   |

Please explain and indicate any information useful to the adult in charge in relation to any of the above health conditions. Indicate any activity to be encouraged or restricted: \_\_\_\_\_

### Part IV: Immunization History (or attach current immunization record)

Year Primary Series Completed

Year of Last Booster

DTaP / DTP / DT (please circle)		
Tdap	_____	_____
MCV (Meningococcal)	_____	_____
IPV (Polio)	_____	_____
MMR	_____	_____
Hepatitis B	_____	_____
Varicella (Chicken Pox)	_____	_____

### Part V: Sunscreen and Insect Repellent

As a parent/guardian I accept responsibility for teaching my daughter how to apply sunscreen and insect repellent, and will make sure my daughter is appropriately dressed for outdoor activities. I will provide sunscreen and insect repellent.

# Annual Permission Form October 1, 20\_\_\_\_ to September 30, 20\_\_\_\_

Complete this form annually at the time of registration. This is retained by the Troop/Group Leader. Parent/guardian should keep a copy of this form and the attached Health History for use when their daughter/ward is attending an event without her Troop.

Name of Girl Scout	Date of Birth	Troop #	
Address	City	State	Zip
Printed Name of Parent(s)/Guardian(s)	Relationship to Child		
Email Address	Primary Phone	Secondary Phone	
Emergency Contact Name	Emergency Phone	Relationship to Child	
Emergency Contact Name	Emergency Phone	Relationship to Child	

Please list adults that are permitted to pick up your daughter from Girl Scout activities, in the event you are unable to. These individuals must be different from your emergency contacts:

Name	Cell Phone	Yes	No
		Receive text messages	
Name	Cell Phone	Yes	No
		Receive text messages	

Yes  No **Permission for Troop and Council-Sponsored Activities:** My daughter/ward has permission to travel to, attend and participate in troop and council-sponsored activities that are 1) located within the Council's jurisdiction and 2) not considered high risk activities.

Initials \_\_\_\_\_

Yes  No **Permission to Participate in Product Programs:** My daughter/ward has permission to participate in the fall product and cookie programs, including online programs. I agree to accept full responsibility for all product ordered and all money she receives and to assist her in making prompt payment for product entrusted to her. I understand that all money collected by my daughter/ward belongs to Girl Scouts of Eastern Missouri and her Girl Scout Troop and is not to be retained by individuals as their property. I understand that product cannot be returned or exchanged. I understand that my daughter/ward may not take product orders before the official start of the product program as determined by Girl Scouts of Eastern Missouri.

Initials \_\_\_\_\_

Yes  No **Permission for Emergency Medical Treatment:** In the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Eastern Missouri to seek treatment for my daughter/ward by a licensed physician pursuant to Missouri law (RsMO 431.061.1). I know of no reasons why my daughter/ward may not participate in prescribed activities except as noted on the Health History Form.

Initials \_\_\_\_\_

Yes  No **Media Permission**  
For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, I hereby consent and agree to the following:

Initials \_\_\_\_\_

1. I hereby grant to Girl Scouts of Eastern Missouri ("GSEM"), and its successors and assigns (each a "Releasee"), the irrevocable, royalty-free, perpetual, unlimited right and permission to use, distribute, publish, exhibit, digitize, broadcast, display, modify, create derivative works of, reproduce or otherwise exploit my name, picture, likeness and voice (including any video footage of the same), testimonials (written by me or attributed to me), interviews (written by me or attributed to me) (collectively, "Media"), or to refrain from so doing, anywhere in the world, by any persons or entities deemed appropriate by GSEM, for any purpose including, without limitation, any use for educational, advertising, non-commercial or commercial purposes in any manner or media whatsoever (whether known or hereafter devised) including, without limitation, on the internet, in print campaigns, in-store and via television. I agree that I have no interest or ownership in any of the Media.

2. I shall have no right of approval, no claim to compensation and no claim (including, without limitation, claims based upon invasion of privacy, defamation or right of publicity) arising out of any use, alteration, blurring, illusionary effect or use in any composite form of my name, picture, likeness and voice. I agree that nothing in this Release will create any obligation on GSEM to make any use of the Media or the rights granted in this Release. I hereby release and hold harmless Releasees from any claim for injury, compensation or negligence resulting or arising from any activities authorized by this Release and any use of the Media by GSEM.

Yes  No **Permission to Survey:** I understand that my daughter/ward may be asked to participate in evaluations and surveys as part of her Girl Scout activities. I understand that her participation is voluntary; she will neither receive compensation of any form for participating, nor will her standing in her Girl Scout programs be affected if she chooses not to participate. I understand that her confidentiality will be protected and her name will not be linked with survey results.

Initials \_\_\_\_\_

A completed Girl Health History form on the reverse side is required.

**Special Accommodations:** My daughter/ward requires the following special accommodations (write "none" if there are none):

**Parent/Guardian Agreement:** I have read and understand the Girl Health History and Annual Permission Form. I may change or revoke any aspect of this agreement at any time by submitting my request, in writing, to the troop/group leader.

Signature of Parent/Guardian

Date