

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
Initials_____ **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.
- Yes No
Initials_____ **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.
- Yes No
Initials_____ **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.
- Yes No
Initials_____ **Media Permission:** I agree to grant Girl Scouts of Eastern Missouri a perpetual, royalty-free, transferable license to use my daughter/ward's name, likeness, image and voice and to use any material I provide to Girl Scouts of Eastern Missouri. I agree that the material I submit does not include any copyrighted material belonging to someone else unless it is in the public domain. I understand that said voice, photograph, likeness and material I submit will be used by Girl Scouts of Eastern Missouri to promote or advertise its mission and will not be offered for sale or consideration. I also agree to release and hold harmless Girl Scouts of Eastern Missouri and its designated directors, officers, employees, agents and affiliated agencies in all matters concerning this release and license.
- Yes No
Initials_____ **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.

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
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