girl scouts of colorado

Troop # _____
Service Unit _____

GIRL HEALTH HISTORY RECORD
Leader Record

(Health history is to be completed and signed by parent/guardian.)

Please keep this information in a safe and confidential place. When this girl is no longer a member, please shred document. To save on time and paperwork, this form may be used for many years if it is reviewed, updated and signed annually. Dates and signatures are at the end of the document. This form must be on site during any Girl Scout activity.

Girl's Name _____ (Last) _____ (First) Date of Birth _____

Parent/Guardian _____ _____

Parent/Guardian Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Name of family physician _____ Phone _____

Family medical/hospital insurance carrier _____ Policy or Group No. _____

Part I: Illnesses and injuries (Check those that apply.)

☐ Ear Infection ☐ Bleeding/Clotting Disorders ☐ Hypertension ☐ Hypotension ☐ Asthma
☐ Hypoglycemia ☐ Heart Defect/Disease ☐ Seizures ☐ Musculoskeletal Disorders
☐ Diabetes ☐ Other (specify) _____

Date of last health examination: _____

Were any complicating medical problems noted in last health examination? _____

Part II: Allergies (Check those that apply and specify nature of allergic reaction.)

☐ Animals _____ ☐ Hay fever _____
☐ Pollen _____ ☐ Food _____
☐ Medicines/drugs _____ ☐ Insect stings _____
☐ Plants _____ ☐ Other (specify) _____

Part III: Other health conditions (Check those that apply.)

☐ Bed wetting ☐ Constipation ☐ Menstrual cramps ☐ Motion sickness ☐ Fainting
☐ Nosebleeds ☐ Sleep disturbances ☐ Emotional disturbances ☐ Wears glasses or contact lenses
☐ Hearing impairment ☐ Sickle cell trait or disease ☐ Special dietary regimen ☐ Other (specify) _____

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

_____

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P. Diptheria; Pertussis (whooping cough); Tetanus		
Td		
Measles		
Mumps		
Rubella (German measles)		
Oral Polio		
Hib		
Tuberculin test (most recent)	Result	
Other _____		

Current medications (need to be in original container with dosage). _____

Dietary restrictions _____

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

Signature of parent/guardian _____ Date _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____

Signature of parent/guardian _____ Updated _____