



Girl Scouts.

GIRL SCOUTS OF WESTERN OHIO
www.girlscoutsofwesternohio.org



HEALTH INFORMATION AND RELEASE FORM

To be completed and reviewed annually by parent/guardian or adult. This form should be kept with the troop records and accompany the troop leader on all troop activities.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Troop # \_\_\_\_\_

PART I: PARENT INFORMATION AND RELEASE

She is under the custodial care of:

Both Parents \_\_\_\_\_ Mother/Guardian only \_\_\_\_\_ Father/Guardian only \_\_\_\_\_ Other (specify) \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_

Address (if different than girl) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Phone (day) \_\_\_\_\_ Phone (evening) \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

Father/Guardian Name \_\_\_\_\_

Address (if different than girl) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Phone (day) \_\_\_\_\_ Phone (evening) \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

PART II: EMERGENCY CONTACT AND RELEASE INFORMATION

In the event that I cannot be reached in an emergency, the following are authorized to act in my behalf:

Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

ADDITIONAL RELEASE INFORMATION:

In addition to the above parent(s)/guardian(s) and Emergency Contacts, this participant may also be released to the following persons:

Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

PART III: HEALTH CARE INFORMATION:

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PART IV: ALLERGIES** (Check those that apply and specify nature of allergic reaction.)

- Animals     Hay Fever     Pollen     Food     Insect Stings     Plants     Penicillin  
 Other Medicines/Drugs: \_\_\_\_\_     Other (specify): \_\_\_\_\_

Girl Scout Leaders do not administer over-the-counter medications for complaints such as headaches, fever, stomach aches, sunburn, etc. If those medications are needed, parents must supply them with written instructions.

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 V: OTHER HEALTH CONDITIONS** (Check those that apply.)

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:

- Asthma     Bed Wetting     Bleeding/Clotting Disorders     Constipation  
 Convulsions/Seizures     Diabetes     Emotional/Behavior Disturbances     Ear Infections  
 Fainting     Hearing Impairment     Heart Defect/Disease     High Blood Pressure  
 Hypertension     Menstrual Cramps     Musculoskeletal Disorders     Motion Sickness  
 Sickle Cell Trait or Disease     Nosebleeds     Rheumatic Fever     Special Dietary Regimen  
 Sleep Disturbances     Urinary Infections     Visual Impairment:     Wears Glasses or Contact Lenses

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

**PART VI: IMMUNIZATION HISTORY**

Immunization	Year Primary Series Completed	Year of Last Booster
DTP Diphtheria; Tetanus; Whooping Cough		
Hepatitis B		
MMR Measles/Mumps/Rubella		
Oral Polio		
TD (Tetanus/Diphtheria)		
Tuberculin Test (most recent) Result		
Others:		

**Which of the following has the participant had?**

- Chicken Pox  
 German Measles  
 Hepatitis  
 Measles  
 Mumps

**PART VII: MEDICATION** (for day outings or overnights only)

Current Medication(s) \_\_\_\_\_  
Being Taken For (condition) \_\_\_\_\_  
Dosage and Frequency \_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION:** This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed troop activities except as specifically noted.

**AUTHORIZATION FOR TREATMENT:** In the event reasonable attempts to contact me at the above listed phone numbers have been unsuccessful, I hereby give my consent to the administration of emergency medical treatment by any licensed physician or dentist and to transfer the child to any reasonably accessible hospital facility. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Is the participant covered by family medical/hospital insurance?  Yes  No

If so, indicate carrier or plan name: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Insurance ID number: \_\_\_\_\_