Girl's Name _____

Health History

Name of Family Physician_____ **Phone** _____

Date of last Tetanus Shot _____ **Date of last Health Examination** _____

Illnesses and injuries (check all that apply):

- ○ Ear infection
- ○ Hypertension
- ○ Seizures
- ○ Asthma
- ○ Other _____
- ○ Bleeding/clotting disorders
- ○ Musculoskeletal disorders
- ○ Heart defect/disease
- ○ Diabetes

Other conditions (check all that apply):

- ○ Bed wetting
- ○ Constipation
- ○ Menstrual cramps
- ○ Motion sickness
- ○ Nosebleeds
- ○ Wears glasses/contact lenses
- ○ Other _____
- ○ Emotional disturbances
- ○ Fainting
- ○ Hearing impairment
- ○ Sickle cell trait/disease
- ○ Sleep disturbances

Allergies (check all that apply; specify nature of reaction):

- ○ Animals _____
- ○ Pollen _____
- ○ Hayfever _____
- ○ Food _____
- ○ Plants _____
- ○ Insect bites/stings _____
- ○ Medicine/drugs _____
- ○ Other (Specify): _____

Special dietary regimen (such as lactose intolerance, vegetarianism, and religious considerations): _____

_____

Activities to be encouraged or restricted: _____

_____

_____

I know of no reason, other than indicated above, why my child should not participate in activities except as noted.
Signature must be in ink.

PARENT'S/GUARDIAN'S SIGNATURE _____ **DATE** _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Girl Health Examination Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The sponsoring council or GSUSA will retain the health form until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but the participant or their legal representative may request copies from the event sponsor. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. *If, due to religious affiliation, you cannot give authorization for emergency medical care, please attach a letter of confirmation from a church official.*

PARENT'S/GUARDIAN'S SIGNATURE _____ **DATE** _____

I am sending the following medication(s) with my child:

Medication	Directions	Time(s) Administered

Please (✓) check any medication your child MAY be given.

☐ Acetaminophen ☐ Ibuprofen ☐ Antibiotic Ointment ☐ Chewable Antacid Tablets ☐ Antihistamine

Parent's/Guardian's Signature: _____ **DATE:** _____

Please complete other side