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

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

- ○ Animals ____
- ○ Pollen ____
- ○ Hayfever ____
- ○ Food ____
- ○ Plants ____
- ○ Insect bites/stings ____________________________________
- ○ Medicine/drugs ______________________________________
- ○ Other (Specify): _____________________________________

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

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