girl scouts of california's central coast

Health History Form

To be completed, signed by parent/guardian, and updated annually

Name_____ Date of Birth_____ Age_____
Address_____ Troop No._____
Parent/Guardian_____ Phone_____
Home Address_____
Business Address_____ Phone_____

In Emergency Notify:
Name_____ Relationship_____
Address_____ Phone_____
Name of Family Physician_____ Phone_____
Family Medical Hospital_____ Address_____
Insurance Carrier_____ Group No._____ Member No._____

Racial/Ethnic Information (Optional information to assist in serving our diverse community)
Spanish/Hispanic ___ American Indian/Alaskan Native ___ Asian/Pacific Islander ___ Black ___ White ___ Other ___

Part I: Illnesses and Injuries (Check all that apply and give appropriate dates.)

Chronic or Recurring Illness:

___ Ear infection ___ Bleeding/clotting disorders ___ Hypertension ___ Asthma
___ Heart defect/disease ___ Musculoskeletal disorders ___ Seizures ___ Diabetes
___ Other (specify)_____

Date of last health examination_____ Currently under the care of a physician or psychologist? ___ Yes ✔ No

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

Since your child's last health exam, has she experienced any of the following?: (Check all that apply)

___ a serious injury requiring medical attention?
___ any prescribed or over-the-counter medication?
___ treatment in a hospital or emergency room?
___ any exposure to a contagious disease?
___ an illness lasting more than five days?
___ a surgical operation or fracture?
___ any restrictions concerning physical activities?

Please explain any "yes" answers to the above questions (include dates):_____

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

___ Animals_____ ___ Hay fever_____
___ Pollen_____ ___ Food_____
___ Plants_____ ___ Insect stings_____
___ Medicines/drugs_____
___ Other (specify)_____

Part III: Other Health Conditions
(Check all that apply)

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

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

Part IV: Immunization History

Has your child received the following immunizations?
(Check all that apply)

___ Hep B ___ DTap/Tdap ___ DT/Td
___ Varicella ___ Hib ___ IPV/OPV
___ PCV7 ___ MMR
___ Other_____

If your child did not receive immunizations or had adverse reactions to one or more immunizations, please explain:

NOTE: Immunization is not mandatory. We respect the rights of parents to elect or decline immunization for their child. However, should we be notified of a possible exposure or threat of exposure to illnesses which are customarily immunized, as a safety precaution, you will be notified and your child will not be allowed to attend camp.

Parent/Guardian Consent:

In the event of an emergency, every effort will be made to contact a parent or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of California's Central Coast to seek treatment for my child or myself by a licensed physician under the Medical Practice Act, pursuant to Section 25.8 of the California Civil Code.

Signature of Parent/Guardian_____

Date_____