

Membership Year ____ / ____
Current Grade in School _____

Girl's name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Current School Name \_\_\_\_\_ School Address \_\_\_\_\_

1. I give permission to certified adults to administer first aid to my girl or seek and have aid given from a physician or hospital if the situation requires. It is my understanding that my girl is covered by Girl Scout Accident Insurance. I do not hold the troop, its' leaders, or the Girl Scouts of Gulfcoast Florida, Inc. at fault in case of accident.
2. I authorize the doctor or hospital personnel to provide emergency medical treatment and or anesthesia to be administered in my/ our absence. This authorization includes, but is not limited to, any emergency treatment and/or surgical procedure(s) deemed necessary by the qualified personnel. I/we understand, that by law, a health facility cannot provide needed treatment unless the parent/guardian is with the child or provides appropriate authorization.
3. As with any social activity, participation in Girl Scouts could present the risk of contracting communicable illness, including COVID-19, and in no way can there be a guarantee that infection will not occur through participation in Girl Scout program activities. Parent/ caregiver will check their girl for signs of communicable illness prior to attending Girl Scout activities, as children may be screened upon arrival. Any child with a communicable disease, including fever, conjunctivitis, or lice, will not be able to participate until no signs of illness are present.

**GIRL HEALTH HISTORY RECORD This health history is to be completed and signed by the parent/guardian of girl.**

Name of physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Family medical/hospital carrier \_\_\_\_\_ Policy or group # \_\_\_\_\_  
 Date of last health examination \_\_\_\_\_  
 Were there any complicating medical problems noted in last health examination? \_\_\_\_\_

**Please note any additional information regarding girl's behavioral, physical, or emotional health and attach to this form.**

<b>HEALTH HISTORY</b> (Please check all that apply)			
<b>Diseases</b>	<b>Allergies</b>	<b>Chronic or Recurring Illness</b>	<b>My girl has permission to take or use the following:</b>
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> German Measles <input type="checkbox"/> Kidney disorders <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Animals _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Hay Fever _____ <input type="checkbox"/> Insect stings _____ <input type="checkbox"/> Medicine/drugs _____ _____ <input type="checkbox"/> Plants _____ <input type="checkbox"/> Pollen _____ <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear infections <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypotension <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Seizures <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Advil/Ibuprofen <input type="checkbox"/> Sudafed/decongestant <input type="checkbox"/> Benadryl/antihistamine <input type="checkbox"/> Pepto Bismol <input type="checkbox"/> Tums/antacid <input type="checkbox"/> Insect repellent <input type="checkbox"/> Hydrocortisone/anti-itch <input type="checkbox"/> Gold Bond/anti-heat rash <input type="checkbox"/> Sunscreen <input type="checkbox"/> Neosporin/triple antibiotic <input type="checkbox"/> Sting stick for insect bites <input type="checkbox"/> Throat lozenges <input type="checkbox"/> Ear drops
<b>SPECIAL NEEDS</b> (check all that apply):		<b>LIST ANY MEDICATIONS - DOSAGE AND FREQUENCY:</b>	
<input type="checkbox"/> Fainting <input type="checkbox"/> Bed wetting <input type="checkbox"/> Constipation <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Wears glasses or contact lenses <input type="checkbox"/> Other _____ Has your girl started her menstrual cycle? Yes <input type="checkbox"/> No <input type="checkbox"/>			

# PARENT/CAREGIVER CONSENT & HEALTH HISTORY FORM

The following person(s) is AUTHORIZED to pick up

Name \_\_\_\_\_ Relationship \_\_\_\_\_

The following person(s) is FORBIDDEN to pick up

Name \_\_\_\_\_ Relationship \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION ONE

In case of emergency notify: \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

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

## EMERGENCY CONTACT INFORMATION TWO

In case of emergency notify: \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

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

## PLEASE INITIAL ALL BELOW

\_\_\_\_\_ **My girl has permission to carry and administer her own medication such as: bronchial inhalers; epipen; or diabetes medication.**

\_\_\_\_\_ **My girl fully understands that she is not allowed to give any medications that she has with her to any other person and will inform the person in charge of first aid when she has taken any of this**

\_\_\_\_\_ **I will alert the troop leader if my girl has tested positive for COVID-19, so that the troop members may be informed. The council will inform families, keeping member health information strictly confidential.**

\_\_\_\_\_ **This health history is complete and accurate to the best of my knowledge. I affirm that my girl's immunizations are up to date.**

\_\_\_\_\_ **This consent form serves as permission for my girl to participate in all Girl Scout activities unless otherwise noted by me in writing.**

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Please note that a new consent form must be completed and submitted each year your Girl Scout returns, to ensure we have the most up-to-date information regarding allergies, medications, and any other important changes.

Troop leaders, please keep a copy of the Parent/Caregiver Consent & Health History Form for each girl. This form *must* accompany you during all Girl Scout meetings, activities, events, and trips.