



GIRL HEALTH HISTORY RECORD

This health history is to be completed and signed by parents/guardians of girls

Sahuaro Girl Scout Council, Inc.
4300 E. Broadway Blvd.
Tucson, AZ 85711
520-327-2288 or 1-800-331-6782

Name	Date of Birth	Age
Address	Troop Number	School
Parent/Guardian	Home Phone Number (520)	
Home Address		
Business Address	Work Phone Number (520)	
In Emergency Notify (Name)	Relationship	
Address	Phone Number (520)	
Name of Family Physician	Phone Number (520)	
Family Medical/Hospital Insurance Carrier	Policy or Group Number	

Part I: Illnesses and injuries (check those that apply and give appropriate dates) Chronic or Recurring Illness

- | | | | |
|--|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other (Specify) _____ | | | |

Date of last health examination: _____ Were any complicating medical problems noted in last health examination? Yes No

Is participant currently under the care of physician or psychologist? Yes No

- | | |
|--|---|
| Since last health exam, has participant had:
a serious injury requiring medical attention? <input type="checkbox"/> | an illness lasting more than five days? <input type="checkbox"/> |
| any prescribed or over-the-counter medication? <input type="checkbox"/> | a surgical operation or fracture? <input type="checkbox"/> |
| treatment in a hospital or emergency room? <input type="checkbox"/> | any restrictions concerning physical activities? <input type="checkbox"/> |

Please explain any "yes" answers to the above questions. Include dates:

Part II: Allergic (check those that apply and specify nature of allergic reaction).

- | | |
|---|--|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Pollen | <input type="checkbox"/> Food |
| <input type="checkbox"/> Medicine/Drugs | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Plants | <input type="checkbox"/> Other |

Part III: Other health conditions (check those that apply)

- | | |
|---|--|
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Emotional Disturbances |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Sickle cell trait of disease |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Special dietary regimen |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Wears glasses or contact lenses |
| <input type="checkbox"/> Other _____ | |

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. Please attach additional sheet(s) of paper if needed.

I know of no reason(s) other than the information indicated on this form, why my child should not participate in prescribed activities except as noted.

Signature of Parent/Guardian _____ Date _____

Emergency Medical Authorization

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while on a Girl Scout activity, when parents and guardians cannot be reached.
I give my consent for emergency medical treatment of my daughter in the emergency room of the nearest hospital, and a certified first aider to provide first aid treatment.

Signature of Parent/Guardian _____ Date _____

Telephone Number _____