

Health History and Parent Permission Form

Full Name: _____ Nickname: _____

Address: _____ City & State: _____ Zip: _____

Birthdate: _____ Service Unit: _____ Troop # or Juliette: _____

Month / Day / Year

Custodial Parent/Guardian Information

Name: _____ Relationship: _____

Best Contact Number: _____ Email: _____

Name: _____ Relationship: _____

Best Contact Number: _____ Email: _____

Emergency Contact Information

Name: _____ Relationship: _____

Best Contact Number: _____ Email: _____

Address: _____ City & State: _____ Zip: _____

Past Illness	Allergies	Allergic Reaction	Other	Behavioral/Learning
<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Fainting	<input type="checkbox"/> ADHD
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Insect Stings		<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Autism Spectrum Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Drugs (Specify)		<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bipolar
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Food (Specify)		<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Anxiety
<input type="checkbox"/> _____	<input type="checkbox"/> _____		<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____		<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	

Are immunizations current? Yes No

Participant is taking the following medications (include times, dosage and reason for taking): _____

Been hospitalized? Yes No If yes, explain when and why: _____

Medical Insurance Company: _____ Medical Insurance Policy # _____

Physician's Name: _____ Physician's Phone: _____

Dentist Name: _____ Dentist Phone: _____

Hospital Preference: _____

<p>Special Dietary Restrictions The following dietary restrictions apply to this individual:</p>	<p>Does not eat: (circle) red meat pork poultry eggs dairy seafood gluten Other notes:</p>
<p>Special Activity Restrictions Explain any restrictions to activity (i.e. what cannot be done, what adaptations or limitations are necessary)</p>	

Permission for Basic Medical Treatment

By checking off the following items, I (parent/guardian) hereby give permission for the Troop leader, event/camp staff, or appointed first aider to administer the marked over-the-counter medications or generic equivalents if the on-site health care personnel deems it to be necessary. Dosage will be administered according to directions on the product.

<input type="checkbox"/> Acetaminophen/Tylenol – Adult or Children (headache, menstrual cramps, muscle cramps, fever)	<input type="checkbox"/> Ibuprofen – Adult or Children (headache, menstrual cramps, muscle cramps, fever, ear aches)
<input type="checkbox"/> Tecnu/Rhullgel/Ivy Dry/Calamine lotion (poison ivy, bug bites)	<input type="checkbox"/> Ludens Throat Drops/Cipacol lozenges/Chloraseptic (sore throat)
<input type="checkbox"/> Children’s Pepto-Bismol/Tums/Roloids (upset stomach/diarrhea)	<input type="checkbox"/> Benadryl – Adult or Children – liquid or lotion (insect bites, allergy symptoms, allergic reaction)
<input type="checkbox"/> Triple Antibiotic Cream/Neosporin (skin abrasions/minor cuts & burns)	<input type="checkbox"/> Talcum Powder/Baby Powder (skin irritations, heat rash)
<input type="checkbox"/> Sudafed liquid or tablets (stuffy nose)	<input type="checkbox"/> Robitussin DM (cough)
<input type="checkbox"/> Claritin (allergy symptoms)	<input type="checkbox"/> Hydrocortisone cream (insect bites, sunburn)
<input type="checkbox"/> Claritin D (allergy symptoms)	<input type="checkbox"/> Lamisil (athlete’s foot)
<input type="checkbox"/> Foille/Solarcaine/Aloe Vera Gel (sunburn)	<input type="checkbox"/> Epsom Salt (muscle strains, skin irritations)
<input type="checkbox"/> Oatmeal Bath – Aveeno or similar (poison ivy)	<input type="checkbox"/> Hydrogen Peroxide (minor cuts, scrapes, burns)
<input type="checkbox"/> Desitin (skin irritations, heat rash)	<input type="checkbox"/> Campho-Phenique (cold sores, insect bites, sunburn)
<input type="checkbox"/> Anbesol (tooth aches)	

Is your child allergic to sunscreen or bug spray? Yes No
 If they are not allergic, can it be provided/applied, if needed? Yes No

By signing below, I grant permission for my daughter to attend **ALL TROOP/GROUP ACTIVITIES** for the 2018-2019 Girl Scout Year. I understand that I may rescind this permission at any time.

Parent/Guardian Signature

Date