

Health History and Parent Permission Form

Full Name: _____ Nickname: _____
 Address: _____ City & State: _____ Zip: _____
 Birthday: _____ 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"/> _____

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: _____

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

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/Rolaids (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"/> Anbesol (tooth aches)
<input type="checkbox"/> Desitin (skin irritations, heat rash)	<input type="checkbox"/> Campho-Phenique (cold sores, insect bites, sunburn)

Is your child allergic to sunscreen? Yes No
 Is your child allergic to 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 GIRL SCOUT ACTIVITIES** for the 2023-2024 membership year. I understand that I may rescind this permission at any time.

 Parent/Guardian Signature

 Date