girl scouts
of new mexico trails

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***
☐ Ear Problems	☐ Hay Fever		☐ Fainting	☐ ADHD
☐ Convulsions	☐ Insect Stings		☐ Contact Lenses	☐ Autism Spectrum Disorder
☐ Asthma	☐ Drugs (Specify)		☐ Diabetes	☐ Bipolar
☐ Heart Disease	☐ Food (Specify)		☐ Nosebleeds	☐ Anxiety
☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____	☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____		☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____	☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

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:
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. I also permit my Cadette, Senior, or Ambassador (if applicable) to self-administer their own over-the-counter medication in the presence of the adult first aider.

☐ Acetaminophen/Tylenol – Adult or Children (headache, menstrual cramps, muscle cramps, fever)	☐ Ibuprofen – Adult or Children (headache, menstrual cramps, muscle cramps, fever, ear aches)
☐ Tecnu/Rhullgel/Ivy Dry/Calamine lotion (poison ivy, bug bites)	☐ Ludens Throat Drops/Cipacol lozenges/Chloraseptic (sore throat)
☐ Children's Pepto-Bismol/Tums/Rolaids (upset stomach/diarrhea)	☐ Benadryl – Adult or Children – liquid or lotion (insect bites, allergy symptoms, allergic reaction)
☐ Triple Antibiotic Cream/Neosporin (skin abrasions/minor cuts & burns)	☐ Talcum Powder/Baby Powder (skin irritations, heat rash)
☐ Sudafed liquid or tablets (stuffy nose)	☐ Robitussin DM (cough)
☐ Claritin (allergy symptoms)	☐ Hydrocortisone cream (insect bites, sunburn)
☐ Claritin D (allergy symptoms)	☐ Lamisil (athlete's foot)
☐ Foille/Solarcaine/Aloe Vera Gel (sunburn)	☐ Epsom Salt (muscle strains, skin irritations)
☐ Oatmeal Bath – Aveeno or similar (poison ivy)	☐ Anbesol (tooth aches)
☐ Desitin (skin irritations, heat rash)	☐ 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 2025-2026 membership year. I understand that I may rescind this permission at any time.

Parent/Guardian Signature _____ Date _____