girl scouts western oklahoma

Girl/Adult Health History Form w/ Physical

October 1, 20___ to September 30, 20___

Please download and save this form before entering the information. You may also choose to print and complete the form manually. Kindly print clearly.

Name:	Troop:	Program Level: D B J C S A Adult
Email Address	Phone:	Date of Birth
Address:	City/State	Zip Code

Additional Girl Information

Parent/Legal Guardian:	☐ Parent ☐ Guardian ☐ Other _____	
Email:		Primary Phone:
Parent/Legal Guardian:	☐ Parent ☐ Guardian ☐ Other _____	
Email:		Primary Phone:

HEALTH INFORMATION PRIVACY STATEMENT

All records will be handled by staff/volunteer(s) whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteer(s) in order to provide adequate participant safety and health care. The health history record will be retained by Girl Scouts – Western Oklahoma, Inc., the sponsoring council, or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the event sponsor by the participant or their legal representative.

Insurance Information:

Name of Family DENTIST:		Phone:
Name of family PHYSICIAN:		Phone:
Name of Carrier:		Policy #
Insured's Name:		Member ID#
Insured's Employer (if insurance is through work)		Phone:
Others who could be contacted to authorize treatments:		
Name:	Relationship to Girl:	Phone:
Name:	Relationship to Girl:	Phone:

Dietary Needs/Restrictions/Special Accommodations: Please list here. Use back of page if needed.

Part A Allergies	Check those that apply. Specify cause and nature of reactions (i.e., Penicillin causes hives.)
	☐ Animals: _____ ☐ Insect Stings: _____ ☐ Pollen: _____
	☐ Hay fever: _____ ☐ Plants/Trees: _____ ☐ Other: _____
	☐ Food: Please list:
	☐ Medicine/Drugs
	In case of an alergic reaction, respond by

Part B Medical History	Check those that apply.		
	☐ ADD/ADHD	☐ Ear Infection, frequent	☐ Mumps
	☐ Arthritis	☐ Eating Disorders	☐ Muscle Disease/Disorder
	☐ Asthma	☐ Emotional Disturbances	☐ Nervous System Disorder
	☐ Anxiety	☐ Epilepsy	☐ Nosebleeds, frequent
	☐ Athletes Foot	☐ EYES: Contact Lenses	☐ Orthodontic Appliances
	☐ Bed Wetting	☐ EYES: Glasses	☐ Physical Disabilities
	☐ Bipolar Disorder	☐ Fainting	☐ Chronic Runny Nose
	☐ Bleeding/Clotting Disorder	☐ Hay Fever	☐ Seizures
	☐ Bronchitis	☐ Headaches, frequent	☐ Sickle Cell Trait or Disease
	☐ Chicken Pox	☐ Hearing Impairment	☐ Skeletal Disease/Disorder
	☐ Concussion	☐ Heart Defect/Disease	☐ Skin Conditions
	☐ Constipation	☐ Hepatitis A/B/C	☐ Sleep Disturbance/ Walking
	☐ Convulsions	☐ Hypertension	☐ Special Dietary Regiment
	☐ Chronic Cough	☐ Kidney Disease	☐ Stomach Upsets
	☐ Depression	☐ Measles	☐ Visual Impairments
	☐ Diabetes	☐ Motion Sickness	
	☐ Other:		

Please explain. Indicate any information useful to the adult in charge in relation to any of the health conditions chosen in Part B. Indicate any activity to be encouraged or restricted.

Medications	Listed are all the prescribed and over-the-counter medications my child will routinely take. Attach a separate list if necessary. *All prescriptions must be in their original container.		
	Medication	Dosage	How often?
Please initial below if applicable	Enter name of Girl Scout:_____ will self-administer the following medication(s).		
*	☐ Bronchial Inhaler		
*	☐ Diabetic Medication		
*	☐ Epi-pen		
*	☐ Other		

Please note, we can only administer prescription medication according to directions on the label, unless we have a signed doctor's note.

Over-The-Counter Medications	Over-the-Counter medications will be used to treat routine illness per treatment protocols. Acetaminophen is used in place of aspirin.			
She can have:	☐ Pain Medication	☐ Cough Syrup	☐ Antibiotic Ointment	☐ Fever Reducer
	☐ Digestive Relief	☐ Other		
She cannot have:				

Part C Immunization & Disease History	Required: Please Complete or Attach a Copy of Immunization Record		
	Immunization	Date	Has had Disease Yes or NO
	Chicken Pox		
	COVID-19		
	D.T.P.		
	Diphtheria		
	Hepatitis B		
	HIB (Hemophilus influenzae B)		
	Measles		
	Mumps		
	Oral Polio		
	Pertussis (whooping cough)		
	Rubella (German Measles)		
	Td (tetanus/diphtheria)		
	Tetanus		
	Tuberculin Test Result (most recent)		
	Other:		

Transportation Release

☐ Yes ☐ No Initials: _____	I authorize transportation for myself/my child by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for the benefit/safety/well-being of myself/my child. It is my expressed intention to hold Girl Scouts – Western Oklahoma, Inc. harmless for any and all injuries, death or damages arising from or any way related to any such transportation.

Consent to Treat

☐ Yes ☐ No Initials: _____	I hereby give permission to the physician selected [by the trip coordinator] to order x-rays, routine tests, and treatment for the health of my child, in the event that I cannot be reached in an emergency. I hereby give permission to the physician selected by the first aider/trip coordinator to hospitalize, secure proper treatment for and to order injection and/or anesthesia and or surgery for my child as name above. I also give my consent for my child to be tested for COVID-19 virus while participating at a trip or overnight event by the event first aider, using an over-the-counter test, should my child become ill or exhibit COVID symptoms. If permission is not given for COVID19 testing, I agree to pick up my child as soon as possible after the first aider has contacted me. The information disclosed on this form may be released to Volunteer/Staff responsible for this activity, including, but not limited to, troop/group leaders, drivers, medical personnel, etc.

Authorization

☐ Yes ☐ No Initials: _____	This health history is correct as far as I know, and the person herein described has permission to engage in all planned activities except as noted by the examining physician or me. By allowing myself/my child to participate in Girl Scout activities and events: a) I acknowledge that an inherent risk of exposure to COVID-19 exists for any in-person activity, including meetings, activities, events, and trips; and b) I am voluntarily assuming all risks related to exposure to COVID-19 and agree not to hold Girl Scouts – Western OK, Inc., or any of it directors, employees, agents, or volunteers, liable for any illness or injury. I have read the above procedures for handling the health history form information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Signature of Participant or Parent/Guardian (if under 18) _____ Date _____

Print Name of Participant or Parent/Guardian (if under 18) _____ Relationship to Child _____

Email Address _____ Phone _____

Record of Health Examination – only required for events that run longer than 3 nights. To be completed within 24 months of event attendance by a **licensed physician** – MD, Physician's Assistant or Nurse Practitioner acting under the supervision of a licensed MD.

Name:			Date of Birth:
Applicant Height:	Applicant Weight:	Blood Pressure:	
I have examined the above applicant within the past 24 months.		Date of Exam:	
In my opinion, the above applicant's condition ☐ does ☐ does NOT preclude her participation in an active program.			
Activities to be limited:			
The applicant is under the care of a physician for the following condition(s):			
Current Treatment (including medications):			

Signature of Physician: _____

Name of Physician: _____

Physician's Office Address: _____

Physician's Office Phone #: _____

Date Signed: _____