GIRL SCOUTS-WESTERN OKLAHOMA INC.
GIRL/ADULT HEALTH HISTORY RECORD

Health History: (Check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions
Chicken Pox Measles German Measles Mumps Rheumatic Fever Tuberculosis Kidney Other (specify)	Animals Food (specify) Hay Fever Insect Stings Medicine/Drugs Plants Pollen Other (specify)	Ear Infections Heart Defect/Disease Seizures Bleeding Disorders Asthma Hypertension Diabetes Musculoskeletal Disorders Arthritis Sinusitis Other	Tylenol/ acetaminophen Advil/Ibuprofen Sudafed/Decongestant Benadryl/Antihistamine Pepto Bismol Robitussin/Expectorant Swimmers Ear Suggestions below

Please describe condition and give dates:

Date of last Tetanus Shot: (month/year) _____

Operations or serious injuries_____

Hospitalizations_____

Other diseases/disabilities_____

Fainting Sleep Disturbances Bed Wetting Menstrual Cramps Constipation Nosebleeds
Emotional disturbances Other_____

Is participant restricted or limited from participating in any physical activity?
Yes No If yes, please explain:_____

Does participant take any prescribed medications or over the counter drugs on a regular basis?
Yes No If yes, please state medication and reason:

_____

_____

Special medical or dietary regimen to be followed (specify)_____

For Girl Health History ONLY:

Authorization for First Aid administration

As the parent/guardian, I authorize the certified First Aider(s) to administer the following to me child, if needed, or deemed necessary,

Acetaminophen 250mg or 500mg Adhesive bandage Analgesic, external Antacid/anti-gas
Antibiotic ointment Antiseptic liquid Aspirin 325mg (adults only) Sunscreen Butterfly Bandage
Ibuprofen (age 12 and up) Insect repellent Rubbing Alcohol Other_____

If not authorized, only basic treatment will be performed which means none of the aforementioned items will be used if your child needs First Aid. Only water will be used.

Parent/Guardian Initial_____

Authorization of Medical Care of a Minor

I;_____the undersigned having legal custody or the legal guardian of _____ consent to an x-ray exam, medical or surgical or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician, surgeon or dentist licenses under the laws of the State of Oklahoma, in giving this consent, I recognize and understand where the above named minor requires immediate medical or hospital care it may not be possible to contact me, and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risks of all treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his/her professional judgment and assess the risks incident to and choose the necessary treatment and to render such care and perform such treatment as he/she determines to be necessary for the health and safety of the above named minor. This health history is complete and accurate. My daughter has permission to engage in all prescribed activities; except as noted by me and the examining physician.

SIGNATURE: _____DATE: _____

Adult participant or parent/guardian for minor

Name (Last, First, MI): _____ Date of Birth:_____ (Girl Form Only) Parent/Guardian:_____

Address: _____ City:_____ Zip:_____ Day Phone:_____

Emergency Contact (other than parent/guardian): _____ Evening Phone:_____

Name of Physician: _____ Cell Phone:_____

Carrier:_____ ID Number_____ Group Number_____

Member Service Phone Number_____ Address:_____

HEALTH HISTORY RECORD HEALTH EXAM

Name: _____ Date: _____

(This part to be completed by physician after review of health history with parent/guardian, and before attending extended trips-3 nights+)

Health Examination:

Height _____Weight B.P.
Appearance-Nutrition _____
Without Glasses With Glasses
Eyes R 20/ ____ L 20/ R 20/ ____L 20/
Ears_____ Hearing R L

Code: Satisfactory =S | Not satisfactory = NS | Not examined = NE

Nose _____ Throat
Teeth_____ Heart
Lungs _____ Abdomen
Genitalia _____ Hernia
Skin_____ Musculoskeletal
General physical and emotional status
_____
Other notes _____

Physician's comments and recommendations
Give details or indicate management or significant illnesses.

Record of Immunization:

Immunization	Year Primary Series Completed	Year Of Last Booster
DTP		
Diphtheria		
Pertussis (Whooping Cough)		
Tetanus (within last 10 years)		
Td		
Oral polio/IPV		
Measles		
Mumps		
Rubella		
Hib		
Hep B		
Tuberculin test	Yr. last given __	Result
Other		
Typhoid and Paratyphoid		
Cholera		
Yellow Fever		
Typhus		
Rocky Mountain Spotted Fever		

This person is in satisfactory condition and may engage in all usual activities except as noted.
Licensed physician's name:

Licensed physician's signature:

Address _____

City _____ State Zip

Phone(_____)_____ Date

HEALTH INFORMATION PRIVACY STATEMENT

The **Health Examination Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers 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/volunteers in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

SIGNATURE: _____ DATE: _____

Adult participant or parent/guardian for minor