girl scouts
heart of new jersey

Girl Scout Health History Record

Girl Scouts must have a current Health History Record on file for all troop meetings and trips. This form must be completed by the Girl Scout's parent/guardian. The intent of this form is to provide troop/group volunteers and healthcare personnel the background to provide appropriate care. When traveling as a troop/group, one copy should stay with the troop/group, the other should remain with the troop/group's at-home emergency contact.

GIRL SCOUT INFORMATION

Girl Scout Name	Birth Date	Troop #	
Address	City	State	Zip

Parent/Guardian #1 Name	Parent/Guardian #1 Phone
Parent/Guardian #2 Name	Parent/Guardian #2 Phone

EMERGENCY CONTACTS (OTHER THAN PARENTS/GUARDIANS LISTED ABOVE)

Name	Phone #	Relation to Girl Scout
Name	Phone #	Relation to Girl Scout

PHYSICIAN AND INSURANCE INFORMATION

Family Physician	Physician Phone #
Insurance Carrier	Policy/Group #
Name of Primary Insured	Primary Insured's Date of Birth

Date of last physical examination

During this examination, were any medical issues noted?

If yes, please explain

HEALTH CONDITIONS

Check all that apply.

☐ ADD/ADHD	☐ Chronic/recurrent illness	☐ Frequent ear infections	☐ Lung disease
☐ Asthma	☐ Diarrhea/constipation	☐ Frequent headaches	☐ Mononucleosis
☐ Anxiety	☐ Diabetes	☐ Head injury	☐ Motion sickness
☐ Autism spectrum	☐ Development/learning disorder	☐ Hearing loss	☐ Pass out/dizziness after exertion
☐ Back or joint pain	☐ Eating disorder	☐ Heart defect/disease	☐ Skin conditions (eczema, rash, etc.)
☐ Bleeding/clotting disorder	☐ Emotional issues/diagnosis	☐ Hypertension	☐ Social issues
☐ Chest pain during/after exercise	☐ Epilepsy/seizures	☐ Insect sting reaction	☐ Vision impairment
☐ Convulsions	☐ Food allergies	☐ Kidney disease	☐ Wears glasses, contacts, protective eyewear
☐ Other (explain)			

ALLERGIES

List any known medication, food, or other allergies. Specify the allergy and reaction.

IMMUNIZATION HISTORY

◯ I certify that all immunizations required for school are up to date, including tetanus.

Date of last tetanus shot:

◯ I choose not to disclose any immunization history. I take full responsibility if illness occurs as a result of attending a Girl Scout event and not providing immunization history. I also understand that my Girl Scout cannot attend events that require immunization records, unless presented at that time.

MEDICATIONS

EpiPen ☐ Can they self-administer their EpiPen? No

Inhaler ☐ Can they self-administer their inhaler? No

Insulin ☐

Other (please explain):

EpiPens, inhalers, and insulin may be carried by the Girl Scout. All other prescription or over-the-counter medications must be kept in the possession of the troop/group first aider or leader. If you require that a troop/group first aider or leader administer medication(s) to your Girl Scout during troop activities, you must first submit the **Girl Scout Medication Authorization** to your troop/group leader.

MEETING YOUR GIRL SCOUT'S NEEDS

Specify any activities your Girl Scout should NOT participate in.

Are there any physical, social, learning, or emotional challenges of which troop/group volunteers should be aware? This information will help volunteers better support your Girl Scout.

HEALTH INFORMATION PRIVACY STATEMENT

This Girl Scout Health History Record may be used solely for the benefit of the Girl Scout participant, to provide adequate participant safety and healthcare. Access to this information will be limited, but copies may be requested from the event sponsor by the participant or their legal representative. This release and waiver shall be effective for one year following the Girl Scout Health History Record completion date below. After that date, the troop/group first aider or leader shall either destroy this form or return to the Girl Scout's parent/guardian for their records.

MEDICAL RELEASE AND WAIVER

☐	The above health history is accurate and complete to the best of my knowledge.
☐	I know of no reasons, other than those indicated on this form, why my Girl Scout should not participate in general Girl Scout activities.
☐	This completed form may be printed/photocopied.
☐	The person described herein has my permission to engage in all prescribed activities except as noted above.
☐	I give permission for GSHNJ staff or volunteers to release this information to emergency responders, hospital personnel, pharmacy staff, etc. I understand that every effort will be made to contact me prior to admission.
☐	I hereby give permission to medical personnel selected by GSHNJ to provide necessary healthcare; to administer medication; to order X-rays, tests, treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation for me.
☐	If I cannot be reached in an emergency, I hereby give permission to the physician to secure and administer treatment, including hospitalization, and to order injections and/or anesthesia and/or surgery for the Girl Scout named above.

In witness whereof, this release and waiver has been carefully read and the contents of this document are understood by the undersigned. This release and waiver shall be effective for one year following the Girl Scout Health History Record completion date. The undersigned freely executes this release and waiver on the date shown below.

Parent/Guardian Name:	
Parent/Guardian Signature:	
Date:	