Girl Scouts of Western Ohio
HEALTH INFORMATION AND RELEASE FORM

To be completed and reviewed annually by parent/guardian or adult. This form should be kept with the troop/group records and accompany the troop/group leader on all troop/group activities. It is designed to provide the troop/group leader with the information needed to access medical care for your daughter. It should be reviewed and updated (as needed) when information changes.

Name: _____ Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____ Troop/Group #: _____

PART I: PARENT INFORMATION AND RELEASE

She is under the custodial care of:

Both Parents ☐ Mother/Guardian only ☐ Father/Guardian only ☐ Other (specify) _____

Mother/Guardian Name _____

Address (if different than girl): _____

Employer: _____ Occupation: _____

Phone (day): _____ Phone (evening): _____ Cell Phone: _____

Email: _____

Father/Guardian Name _____

Address (if different than girl): _____

Employer: _____ Occupation: _____

Phone (day): _____ Phone (evening): _____ Cell Phone: _____

Email: _____

PART II: EMERGENCY CONTACT AND RELEASE INFORMATION

In the event that I cannot be reached in an emergency, the following are authorized to act in my behalf:

Name: _____ Relationship to Participant: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship to Participant: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

ADDITIONAL RELEASE INFORMATION:

In addition to the above parent(s)/guardian(s) and emergency contacts, this participant may also be released to the following persons:

Name: _____ Relationship to Participant: _____

Name: _____ Relationship to Participant: _____

PART III: HEALTH CARE INFORMATION:

Physician's Name: _____ Phone: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Dentist's Name: _____ Phone: _____

Dentist's Address: _____ City: _____ State: _____ Zip: _____

PART IV: ALLERGIES *(Check those that apply and specify nature of allergic reaction.)*

☐ Animals ☐ Hay Fever ☐ Pollen ☐ Food ☐ Insect Stings ☐ Plants ☐ Penicillin

☐ Other Medicines/Drugs: _____ ☐ Other (specify): _____

Girl Scout Leaders do not administer over-the-counter medications for complaints such as headaches, fever, stomachaches, sunburn, etc. If those medications are needed, parents must supply them with written instructions.

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted:

PART V: OTHER HEALTH CONDITIONS *(Check those that apply.)*

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted:

☐ Asthma	☐ Bed Wetting	☐ Bleeding/Clotting Disorders	☐ Constipation
☐ Convulsions/Seizures	☐ Diabetes	☐ Emotional/Behavior Disturbances	☐ Ear Infections
☐ Fainting	☐ Hearing Impairment	☐ Heart Defect/Disease	☐ High Blood Pressure
☐ Hypertension	☐ Menstrual Cramps	☐ Musculoskeletal Disorders	☐ Motion Sickness
☐ Sickle Cell Trait or Disease	☐ Nosebleeds	☐ Rheumatic Fever	☐ Special Dietary Regimen
☐ Sleep Disturbances	☐ Urinary Infections	☐ Visual Impairment:	☐ Wears Glasses or Contact Lenses

☐ Other (specify): Please explain any items that are checked. Indicate any information that would be useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

_____

_____

_____

PART VI: IMMUNIZATION HISTORY

Immunization	Year Primary Series Completed	Year of Last Booster
DTP (Diphtheria; Tetanus; Whooping Cough)		
Hepatitis B		
MMR (Measles/Mumps/Rubella)		
Oral Polio		
TD (Tetanus/Diphtheria)		
Tuberculin Test (most recent) Result		
Others:		

Which of the following has the participant had?
☐ Chicken Pox
☐ German Measles
☐ Hepatitis
☐ Measles
☐ Mumps

PART VII: MEDICATION *(For day outings or overnights only.)*

Current Medication(s): _____

Being Taken For: (condition) _____

Dosage and Frequency: _____

EMERGENCY MEDICAL AUTHORIZATION: This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed troop/group activities except as specifically noted.

AUTHORIZATION FOR TREATMENT: In the event reasonable attempts to contact me at the above listed phone numbers have been unsuccessful, I hereby give my consent to the administration of emergency medical treatment by any licensed physician or dentist and to transfer the child to any reasonably accessible hospital facility. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian: _____ Date: _____

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name: _____ Policy or Group #: _____

Name of insured: _____ Relationship to participant: _____

Insurance ID number: _____