

GIRL SCOUTS OF SAN FRANCISCO BAY AREA
GIRL HEALTH HISTORY RECORD

ALL INFORMATION TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN OF GIRL ANNUALLY

PART I: GIRL RECORD

Girl's Name	School Attending	Birth Date	Troop Number
Address/City/State/Zip		Family E-Mail Address (For GSSFBA use only)	
Mother's Name	Day Time Telephone ()	Evening Phone ()	
Father's Name	Day Time Telephone ()	Evening Phone ()	
Is your girl/ward disabled? <input type="checkbox"/> NO <input type="checkbox"/> YES		If YES, does she need accommodation? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Do we have your permission for your child/ward to receive emergency medical treatment if needed? <input type="checkbox"/> NO <input type="checkbox"/> YES			

HEALTH INFORMATION PRIVACY STATEMENT

The **Girl Health History Record** is for health care concerns at the specified events 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 history record will be retained by the sponsoring council 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 history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Parent/Guardian Signature: _____ Date: _____

This information is needed to measure how well your council is serving the Bay Area's diverse population.

The girl's racial background is: (please check as many as apply) American Indian or Alaskan Native Asian
 Black or African American Hawaiian or Pacific Islander White Other (specify) _____

The girl's ethnic background is: (please check one) Hispanic or Latino Not Hispanic or Latino

Parent/Guardian Signature	Date	Telephone Number	Cell Phone Number ()
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PART II: EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN

Name	Relationship	Day Phone ()	Evening Phone ()
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PART III: HEALTH INSURANCE INFORMATION

Name of family DENTIST: _____ Telephone: () _____

Name of family PHYSICIAN: _____ Telephone: () _____

Family Medical/Hospital INSURANCE CARRIER: _____ POLICY/GROUP NUMBER: _____

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) Check here for no known allergies

Animals _____ Hay Fever _____ Medicines/Drugs _____ Pollen _____
 Food _____ Insect Stings _____ Plants _____ Other (specify) _____

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates) Other Chronic/Recurring Illnesses (specify) _____

Asthma _____ Diabetes _____ Heart Defect/Disease _____ Musculoskeletal Disorder _____
 Bleeding/Clotting Disorders _____ Ear Infection _____ Hypertension _____ Seizures _____

Date of last health examination: _____

Were any complicating medical problems noted in last health examination? NO YES If YES, what? _____

Other Health Conditions: (Check those that apply) Other (specify): _____

Attention Deficit Disorder (ADD) Down's Syndrome Hearing Impairment Nose Bleeds Wears Glasses/Contacts
 Bed Wetting Emotional Disturbances Menstrual Cramps Sickle Cell Trait/Disease Special Dietary Regimen
 Dental Braces Fainting Motion Sickness Sleep Disturbances Visual Impairment

PART V: MEDICATION

Is your girl taking any medications? NO YES
If YES, list medication, reason, and possible side effects.

MEDICATION	REASON	POSSIBLE SIDE EFFECTS

Activity Restrictions? NO YES
If YES, list restrictions.

PART VI: IMMUNIZATION HISTORY

The following is my girl's immunization history:

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P. <small>Diphtheria, tetanus and pertussis (whooping cough)</small>		
Td		
Measles.....		
Mumps.....		
Rubella (German measles).....		
Polio		
Hbpv		
Tuberculin Test (most recent) ..	Result: _____	
Other (Specify): _____		

I/We have chosen **not** to immunize my/our girl.

Parent/Guardian Signature _____ Date _____