girl scouts
of ohio's heartland

Health History, Emergency Contact Information, and Permission to Treat with First Aid and Medical Authorization Form

Child's Name: ______________________ Date of Birth: ______________
Address: ____
City: ______________________ Zip Code: __________ State: __________
School: ______________________ Grade:______ Troop Number: __________

Parent/Guardian Information Child is in the custodial care of:

☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other: ______________________

Parent/Guardian 1: ____
Phone 1: ______________ Phone 2: ______________ Phone 3: ______________
Parent/Guardian 2: ____
Phone 1: ______________ Phone 2: ______________ Phone 3: ______________

Emergency Contacts

Name: ______________________ Relationship: ______________ Phone 1: __________
Phone 2 ______________ Phone 3: ______________
Name: ______________________ Relationship: ______________ Phone 1: __________
Phone 2 ______________ Phone 3: ______________

Health History: Check all that apply and provide requested information.

	Condition	Dates		Condition	Dates		Condition	Dates
	ADD/ADHA			Epilepsy			Muscle Disease/Disorder	
	Arthritis			Fainting			Nervous System Disorder	
	Asthma			German Measles			Sickle Cell Anemia	
	Athletes Foot			Hay Fever			Sinusitis	
	Bed Wetting			Headaches/ Migraines			Skeletal Disease/Disorder	
	Bleeding/Clotting Disorder			Hearing			Skin Conditions	
	Bronchitis			Heart Defect/ Disease			Sleep Disturbance/Walk-ing	
	Chickenpox			Hypertension			Stomach Upsets	
	Colds/Sore Throats			Kidney Disease			Urinary Tract Infections	
	Constipation			Measles			Wear: ○ Contacts ○ Glasses	
	Convulsions			Mononucleosis			Other:	
	Diabetes			Motion Sickness			Other:	
	Ear Infections			Mumps			Other:	

Allergies	Yes	No	Explain yes answers. Include type of allergy (i.e., "peanut allergy" in the food category).
Animals			
Insect stings			
Plants/trees			
Food			
Drugs			
Other			

Any specific needs or accommodations required? ____

Any known behavioral and/or mental health concerns? ____

Any psychiatric counseling or hospitalization? ____

Any operations or serious injuries? ____

Any disabilities or chronic or recurring illnesses? ____

Any activities that are discouraged or limited by your child's physician? ____

____

Any dietary modifications? ____

Has menstruation begun? ☐ Yes ☐ No If not, does she know what it is? ☐ Yes ☐ No

If yes, is her menstrual history normal? ☐ Yes ☐ No

Immunization History

Are all immunizations current? ☐ Yes ☐ No If not, state reason(s): ___________________________

DTP or DT (Tetanus) Date: ________________

Medication Information

Are any prescription medications being taken? ☐ Yes ☐ No

Are any of the following used? ☐ Inhaler ☐ EpiPen

Medication	Reason	Dosage	Frequency

My girl may be given: ☐ Aspirin ☐ Benadryl ☐ Ibuprofen ☐ Neosporin ☐ Tylenol ☐ None

Medical Care and Insurance Information

Physician: ____ Phone: ________________

Dentist/Orthodontist: ____ Phone: ________________

Preferred Medical Facility: ___________________________ Address: ___________________________

Insurance Company: ___________________________ Policy Number: ___________________________

Policy Holder: ____

Please fill out either section one (consent for medical treatment) or section two (refusal of consent for treatment).

Section One: Authorization to Permit Medical Treatment

By signing below, I hereby give permission to the Girl Scouts of Ohio's Heartland Council, Inc. (Girl Scouts), their employees, members, or volunteers to provide routine first aid and to supervise self-medication and to seek medical assistance on behalf of my child in the event my child is injured or becomes ill, and I am unavailable to indicate my wishes regarding treatment. I understand that the Girl Scouts and its members, volunteers, or employees shall not be held responsible for the cost of treatment, and in fact are authorized to bind me as the finanically responsible party for the medical treatment of my child. I hereby grant permission to physicians and other licensed health care providers and their designees to administer medical care through injury or illness evaluation, first aid care, and referral to duly licensed medical personnel when indicated.

I authorize the release of all information on the reverse side of this form to treatment providers, and will hold the Girl Scouts in no way responsible for the release of this information to any party.

Date Granted: ________________ Signature of Parent/Guardian: ___________________________________

Section Two: Refusal to Consent to Medical Treatment

By signing below, I indicate that the Girl Scouts of Ohio's Heartland Council, Inc. (Girl Scouts), its volunteers, or employees are not authorized to allow the administration of health care to my child in the event of injury or sickness. However, I will not hold the Girl Scouts, its employees, members, or volunteers liable in any way for seeking emergency care (such as calling 911) for my child or providing any health information on this form to emergency personnel.

Date Granted: ________________ Signature of Parent/Guardian: ___________________________________

Volunteers must keep the form with the troop at all times.