Print Form

girl scouts of northern new jersey

Girl Health History Form

This health history is to be completed and signed by the parent/guardian of girls attending physically demanding or high risk activities.

Girl Name: _____

Girl Name:			**Date of Birth:** **Age:**
Address:	**# & Street:**		**Service Unit:**
	City:	**State:** **Zip:**	**Troop No.:**
Mother/Guardian:			**Home Phone: ( )**
Address (if different than child):			**Work Phone: ( )**
Business name & address:			**Cell Phone: ( )**
Father/Guardian:			**Home Phone: ( )**
Address (if different than child):			**Work Phone: ( )**
Business name & address:			**Cell Phone: ( )**
Emergency Contact Name: **(other than Parent/Guardian)**			**Relationship to child:**
Primary Phone: ( )		**Cell Phone: ( )**	
Name of Family Physician:			**Phone: ( )**
Primary insurance Carrier:			**Policy or Group #:**

EMERGENCY MEDICAL AUTHORIZATION

In the event that there is an emergency and I cannot be reached, I give permission for the adult in charge to take my daughter _____to a qualified licensed physician or to a nearby hospital for necessary treatment.

I understand that in order to dispense medication that this will not occur unless she/he has written authorization and instructions from the child's doctor to dispense non-prescription and/or prescription medication (including vitamins, nutritional supplements, etc.). All medications must be in their original pharmacy containers, with an intact current prescription label. No exceptions will be made.

I also give permission for my child to receive the following non-prescription medications that I have checked below.

☐ Antacid ☐ Advil ☐ Benadryl ☐ Tylenol ☐ Cough drop ☐ Topical creams / lotions

Signature of parent/guardian: _____ Date: _____

Girl Scouts of Northern New Jersey
www.gsnnj.org

Paramus Service Center
300 Forest Avenue
Paramus, NJ 07652
201-967-8100

Paterson Resource Center
Center City Mall, 301 Main St
Paterson, NJ 07505
973-881-9400

Randolph Service Center
1579 Sussex Turnpike
Randolph, NJ 07869
973-927-7722

Riverdale Service Center
95 Newark Pompton Turnpike
Riverdale, NJ 07457
973-248-8200

Part I: General Health (check those that apply and give appropriate dates)

☐ Ear Infection _____
☐ Hypertension _____
☐ Heart Defect / Disease _____
☐ Seizures _____
☐ Oral Medication _____
☐ Sickle Cell Trait / Disease _____
☐ Other chronic or recurring illnesses and injuries (specify) _____
☐ Bleeding / Clotting Disorders _____
☐ Asthma _____
☐ Musculoskeletal Disorder _____
☐ Diabetes _____
☐ Injected medication _____

Date of last health examination: _____
Were any complicating medical problems noted during last health examination? ☐ No ☐ Yes

Is the participant currently under the care of a physician or psychologist? ☐ No ☐ Yes – Please specify:

_____

Since last health examination, has participant had: (check all that apply)

☐ Serious injury requiring medical attention?
☐ Any prescribed medication?
☐ Treatment in a hospital or emergency room?
☐ An illness lasting more than five days?
☐ A surgical operation or fracture?
☐ Any restrictions concerning physical activities?

Please explain any "yes" answers to the above questions (use additional paper as necessary). Include dates.

_____

_____

Part II: Disease and Immunization History

Which of the following has the participant had?
Please list dates.

☐ Measles _____
☐ Chicken Pox _____
☐ German Measles _____
☐ Mumps _____
☐ Hepatitis A _____
☐ Hepatitis B _____
☐ Hepatitis C _____

Immunization Dates are required.
***"Up to date"* is NOT acceptable**

Vaccine:	*Mo/Yr*	*Mo/Yr*	*Mo/Yr*	*Mo/Yr*	*Mo/Yr*
DTP					
TD (tetanus/diphtheria)					
Tetan Varicella (chicken pox)					
Polio					
MMR					
Haemophilus Influenza B					
Hepatitis B					

TB Mantoux Test: Date of test _____ Result: ☐ Pos. ☐ Neg
H1N1: Date received _____
Influenza: Date received _____

Allergies - Describe reaction, emergency allergy action plan, and doctor's documentation:
Specific Food: _____
Specific Medication: _____
Other Allergies: _____

Health Needs:

☐ Wears contact lenses/ corrective glasses
☐ Wears orthodontic appliance &/or orthopedic device
☐ Wears an insulin pump
☐ Wears medical ID for _____
☐ Has started menstruating - if not, does she know what to expect? ☐ Yes ☐ No
☐ Seizures - What type?_____ Helped by _____
Other: _____

Health Exemptions:

Please feel free to attach additional significant information that will assist us in providing an enriching experience for your daughter.

Part III: HIPPA Privacy Rule: I authorize the use of information to promote and monitor well being while in camp, and as necessary, provision of first aid/ emergency care as best as possible, according and not limited to certifications, training, and availability.

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter/I should not participate in Girl Scout activities except as noted.

Signature of parent/guardian: _____ Date: _____