

To the Parent/Guardian: This form, signed by a parent or guardian, is needed prior to a girl participating in any Girl Scout activity. Parents may wish to make a copy in case daughter participates in Girl Scout program events without her troop.

To the Leader: Retain this form. This information should be with you at all troop functions (including troop meetings, trips and camping events).

Girl's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Home phone(\_\_\_\_) \_\_\_\_\_ Cell phone(\_\_\_\_) \_\_\_\_\_

Parent/ Guardian Name \_\_\_\_\_ Work phone(\_\_\_\_) \_\_\_\_\_

My daughter is under the custodial care of:

Both Parents  Mother Only  Father Only  Other,specify \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Family Medical/Hospital Insurance Carrier \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Emergency Contact Name (other than parent) \_\_\_\_\_

Relationship to girl \_\_\_\_\_ Home(\_\_\_\_) \_\_\_\_\_

Work(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

**Medical Release:** In the event \_\_\_\_\_ becomes ill or sustains an injury while in the care of or under the supervision of the Girl Scout of Greater Mississippi Council or any of its officers or leaders and it becomes necessary to seek professional medical treatment, I give my permission to the certified first aider to provide First Aid and/or CPR and to take the appropriate measures including contacting the emergency medical services (EMS) system and arranging for transportation to \_\_\_\_\_ or the nearest emergency medical facility to receive treatment by a licensed physician. I understand that every effort will be made to contact me or the person designated by me as my emergency contact.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Photo/Press Release:** I, as Parent/Guardian of \_\_\_\_\_, agree that any photographs, and/ or motion picture or videotape for which she posed, and /or audio recordings made of her voice or words written by her may be used by the Girl Scout of Greater Mississippi Council, its assignees or successors, in whatever way desired, including television, CD-ROMS, online and print publications, and any other form for the storage, retrieval and reproduction of information, images; furthermore, I hereby consent that such information photographs, videos, and the plates and/or tapes from which they are made shall be their property, and they have the right to sell, duplicate, reproduce and make other uses of such information, photographs, videos, recordings, plates and tapes as they may desire free and clear of any claim whatsoever on my part.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Health History Form

Date of last health exam \_\_\_\_\_ Were any complicating medical problems noted in the last health exam? \_\_\_\_\_

Are immunizations up to date?  Yes  No Date of last tetanus immunization \_\_\_\_\_

Current medications (Identify medication and explain condition being treated) \_\_\_\_\_

Please check all that apply:

Since her last health exam, has your daughter had:	Allergies:	Chronic or Recurring Illness:	Other Health Conditions:
<input type="checkbox"/> Serious injury requiring medical treatment?  <input type="checkbox"/> Treatment in a hospital or emergency room?  <input type="checkbox"/> Exposure to a contagious disease?  <input type="checkbox"/> Illness lasting more than 5 days?  <input type="checkbox"/> Surgical operation or fracture?  <input type="checkbox"/> Physical activity restriction?	<input type="checkbox"/> Animals _____ <input type="checkbox"/> Insect stings  <input type="checkbox"/> Food _____  <input type="checkbox"/> Medicines/Drugs _____  <input type="checkbox"/> Hay fever <input type="checkbox"/> Plants <input type="checkbox"/> Pollen <input type="checkbox"/> Other _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding/Clotting disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Seizures <input type="checkbox"/> Sinusitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Hypotension <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Sickle Cell Trait/Disease <input type="checkbox"/> Other _____	<input type="checkbox"/> Bed wetting <input type="checkbox"/> Constipation <input type="checkbox"/> Dental braces <input type="checkbox"/> Emotional disturbances <input type="checkbox"/> Fainting <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Motion sickness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Kidney disorders <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Special dietary regimen <input type="checkbox"/> Wears contacts or glasses <input type="checkbox"/> Has begun menstruating <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Other _____

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.

My daughter has my permission to take or use the following (*MUST be administered by the adult in charge*):

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Tylenol/Acetaminophen  | <input type="checkbox"/> Advil/Ibuprofen                        | <input type="checkbox"/> Decongestant |
| <input type="checkbox"/> Benadryl/Antihistamine | <input type="checkbox"/> Pepto-Bismol                           | <input type="checkbox"/> Tums/Antacid |
| <input type="checkbox"/> Robitussin/Expectorant | <input type="checkbox"/> Swimmer's Ear/Alcohol-vinegar solution |                                       |

This health history is complete and accurate. I know of no reason(s), other than the information on this form, why my daughter should not participate in prescribed activities except as noted. I understand that medication needing to be administered to my daughter during a Girl Scout activity must be given to the adult in charge along with written instructions and permission to administer the scheduled dosages.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Year 2 Parent Initial _____ Date _____	Year 3 Parent Initial _____ Date _____
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