Girl Scouts of NE KS & NW MO
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www.girlscoutsksmo.org

Health History Form for Girl Scouts

Must be completed annually by parent or guardian and filed with the troop leader OR within 2 months of GS program lasting 2 nights or less.

The information on this form is gathered to assist us in identifying appropriate care for your daughter during her Girl Scout program. Keep a copy of the completed form for your records. Any changes to this form should be provided upon participant's arrival. Please provide complete information so that health personnel can be aware of your daughter's needs.

Health History

Please type or write clearly and legibly.

Name: (Last, First, Middle Initial)	**Date of Birth:** (XX/XX/XXXX)		**Sex:** ☐ **M** ☐ **F**
Address:	**City:**	**State:**	**Zip:**
Phone:	**Alternate Phone:**	**Age at camp:**	

1. Parent/Guardian Information *Camper lives with this person* ☐ *Yes* ☐ *No*

Name:	**Relationship:**
Day Phone:	**Evening Phone/Cell Phone:**

2. Parent/Guardian Information *Camper lives with this person* ☐ *Yes* ☐ *No*

Name:	**Relationship:**
Day Phone:	**Evening Phone/Cell Phone:**

Emergency Contact Information:

Emergency Contact:	**Relationship:**
Phone:	**Alternate Phone:**

Check all that apply and explain in detail checked answers:

☐	**Physical restrictions**	☐	Fainting
☐	**Asthma or Hayfever**	☐	Constipation
☐	**Diabetes**	☐	Eyesight/Hearing/Speech Impairment
☐	Recent injury, illness or infectious disease	☐	Skin problems (itching, rash, acne, etc.)
☐	Diseases of the Ears or Ear Infections	☐	ADD/ADHD
☐	Convulsions/Epilepsy/Seizures	☐	Headaches/Migraines
☐	Sinus Infections	☐	Eating Disorders (Anorexia, Bulimia, etc.)
☐	Kidney/bladder illness	☐	Nosebleeds
☐	Emotional difficulties requiring professional help	☐	Menstrual cramps
☐	Sleep disturbances/Sleepwalking	☐	Had surgery or hospitalized in the last 5 years
☐	Bed wetting	☐	Other: _____

Please explain in detail all checked answers marked above (for diabetes or asthma, attach a sheet explaining treatment in detail. For asthma, include frequency of attacks, triggers, action plan, peak flows, etc.):

Allergies: Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, insects, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Does the camper suffer from Anaphylaxis? ☐ Yes ☐ No

*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Does the camper carry an Epipen? ☐ Yes ☐ No

Does the camper carry an inhaler? ☐ Yes ☐ No

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Precautions/Restrictions
1.	
2.	
3.	

Name of family physician:_____ Phone (____)_____

Name of family dentist/orthodontist:_____ Phone (____)_____

The person herein named has permission to engage in all activities, including trips beyond the primary program location related to the program, except as noted. I have read the program information provided and understand and agree to comply with all procedures.

This health history is correct and complete as far as I know. I hereby give permission to the Girl Scouts to provide, seek, and consent to routine health care, administration of prescribed medications and emergency treatment for my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the Girl Scouts to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the Girl Scouts be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the Girl Scouts be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510 (b)) to the disclosure to camp representatives of the protected health information of the person herein described as necessary: (i) to provide relevant information to the Girl Scout representatives related to the person's ability to participate in activities; and (ii) in the case of minors, to provide relevant information to the Girl Scout representatives to keep me informed of my child's health status. I authorize any hospital, physician, medical practitioner, clinic, or other related facility to furnish to Mutual of Omaha Insurance Company, or anyone acting on its behalf, all information concerning medical, dental and hospital records for my child, to be used for the purpose of evaluating claims for benefits. I have the right to receive a copy of this authorization upon request.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Girl Scouts to secure and administer treatment, including hospitalization and/or injection and/or anesthesia and/or surgery for the person named above. This completed form may be photocopied for trips beyond the primary program location.

Signature of parent or guardian _____

Printed name _____ Date _____

Witness _____ Date _____