girl scouts of south carolina mountains to midlands

Girl Health History

Girl Scouting builds girls of courage, confidence, and character, who make the world a better place.

To be completed by Caregiver and returned to the troop leader. PLEASE PRINT.

Name _____ Birth Date _____
Last First Middle Initial

Address _____
Street City State ZIP

Email Address _____

Phone (H) _____ (W) _____ (C) _____

Emergency Contact _____
Name Address Phone

Family Medical/Hospital Insurance Carrier _____
Name Policy or Group Number

Check all that apply:

Allergies*	**Chronic Illnesses***	**Immunizations**			**Permission to Administer Medications**
			Year Completed	Year Last Booster	
□ Food	□ Heart Defect/Disease	D.T.P.			□ Advil/Ibuprofen
□ Hay Fever	□ Seizures	Diphtheria			□ Tylenol/Acetaminophen
□ Insect Stings	□ Bleeding Disorders	Pertussis			□ Benadryl/Antihistamine
□ Medicine/Drugs	□ Asthma	Tetanus			□ Pepto Bismol/Generic
□ Plants	□ Hypertension	Td			□ Tums/Antacid
□ Pollen	□ Diabetes	Measles			□ Robitussin/Expectorant
□ Animals	□ Musculoskeletal Disorders	Mumps			□ Sudafed/Decongestant
□ Other (specify)	□ Arthritis	Rubella			□ Anti-itch Gel/Cream
	□ Sinusitis	Oral Polio			□ Neosporin/Generic
	□ Ear Infections	Hib			□ Other (specify)
	□ Other (specify)	Hepatitis			
		Tuberculin test			

*Comments (please explain any items that are checked) _____

_____

Other health conditions:

☐ fainting ☐ sleep disturbances ☐ bed wetting ☐ menstrual cramps
☐ constipation ☐ nosebleeds ☐ emotional disturbances ☐ other _____

Special medical or dietary regimen to be followed (specify) _____

Permission to treat:

In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the troop leader to provide routine health care; to administer prescribed medications; to seek emergency medical treatment; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; to provide or arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the troop leader to secure and administer treatment, including hospitalization, for the person named above.

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

Signature of Caregiver _____ Date _____

Columbia Service Center 1107 Williams Street Columbia, SC 29201 T 803.782.5133 F 803.782.0410
Greenville Service Center Three Independence Pointe, Ste 106 Greenville, SC 29615 T 864.770.1400 F 864.272.3394
Spartanburg Service Center 330 Scout Drive Spartanburg, SC 29301 T 864.576.2514 F 864.587.7367

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