girl scouts of california's central coast

Health History

To be completed, signed and updated annually

<table>
<tr><td colspan="2">CHILD'NAME GENDER_________</td><td>BIRTH DATE _____________</td></tr>
<tr><td colspan="2">CAREGIVER/GUARDIAN NAME</td><td>DOES CAREGIVER LIVE IN HOME WITH CHILD?</td></tr>
<tr><td colspan="2">CAREGIVER/GUARDIAN NAME</td><td>DOES CAREGIVER LIVE IN HOME WITH CHILD?</td></tr>
<tr><td colspan="2">ARE YOU CURRENTLY UNDER REGULAR SUPERVISION OF PHYSICIAN?</td><td>DATE OF LAST PHYSICAL/MEDICAL EXAMINATION</td></tr>
<tr><td colspan="2">NAME OF PHYSICIAN</td><td>FAMILY MEDICAL HOSPITAL</td></tr>
<tr><td colspan="2">DOES CHILD USE ANY SPECIAL DEVICE(S):</td><td>IF YES, WHAT KIND?</td></tr>
<tr><td colspan="2">INSURANCE CARRIER</td><td>GROUP #
MEMBER #</td></tr>
<tr><td colspan="2">EMERGENCY CONTACT</td><td>PHONE NUMBER</td></tr>
<tr><td colspan="2">EMERGENCY CONTACT – NOT LOCAL</td><td>PHONE NUMBER</td></tr>
<tr><td colspan="3">MY CHILD HAS THE FOLLOWING MEDICATION ALLERGIES</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">LIST ANY ALLERGIES WE SHOULD BE AWARE OF</td></tr>
<tr><td>PARENT'S EVALUATION OF CHILD'S HEALTH</td><td colspan="2"></td></tr>
</table>

CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO ________________________________(LEADER/CO-LEADER/CAMP VOLUNTEER) TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O.), OR DENTIST (D.D.S.) FOR _________________________(NAME). THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

PRINTED NAME SIGNATURE & DATE

HOME ADDRESS

HOME PHONE WORK PHONE

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Health History

First Name________________Last Name_________________

Past Illness – Check illnesses that you had and specify approximate dates of illnesses:			
	Dates		**Dates**
☐Asthma		☐Diabetes	
☐Seizures		☐Epilepsy	
☐Heart Disease		☐Whooping cough	
☐Bleeding/clotting disorders		☐Other	

VACCINE 4-6 YEARS OLD ELEMENTARY	VACCINE 4-6 YEARS OLD ELEMENTARY	7 – 17 YEARS OLD ELEMENTARY OR SECONDARY SCHOOL	7TH GRADE*
DIPHTHERIA, TETANUS, AND PERTUSSIS	5 doses of DTaP, DTP, or DT (4 doses OK if one was given on or after 4th Birthday)	4 doses of DTaP, DTP, DT, Tdap, or Td (3 doses OK if last dose was given on or after 2nd birthday. At least one dose must be Tdap or DTaP/DTP given on or after 7th birthday for all 7th-12th graders.)	1 dose of Tdap (Or DTP/DTaP given on or after the 7th birthday.)
	Parent Initial________	Parent Initial__________	Parent Initial__________
MEASLES, MUMPS, AND RUBELLA (MMR OR MMR-V)	2 doses (Both given on or after 1st birthday. Only one dose of mumps and rubella vaccines are required if given separately.)	4 doses of DTaP, DTP, DT, Tdap, or Td (3 doses OK if last dose was given on or after 2nd birthday. At least one dose must be Tdap or DTaP/DTP given on or after 7th birthday for all 7th-12th graders.)	1 dose of Tdap (Or DTP/DTaP given on or after the 7th birthday.)
	Parent Initial___________	Parent Initial____________	Parent Initial__________
HEPATITIS B (HEP B OR HBV	3 doses Parent Initial __________		
VARICELLA (CHICKENPOX, VAR, MMR-V, OR VZV)	1 dose Parent Initial ________	1 dose for ages 7-12 years. 2 doses for ages 13 - 17 years. Parent Initial ______	

Additional Emergency Contacts

Name	Phone Number	Alternate Phone Number
Name	Phone Number	Alternate Phone Number