girl scouts of california's central coast

# Health History

**To be completed, signed and updated annually**

| | |
|---|---|
| CHILD'NAME SEX | BIRTH DATE |
| PARENT/GUARDIAN 1 NAME | DOES PARENT/GUARDIAN 1 LIVE IN HOME WITH CHILD? |
| PARENT/GUARDIAN 2 NAME | DOES PARENT/GUARDIAN 2 LIVE IN HOME WITH CHILD? |
| ARE YOU CURRENTLY UNDER REGULAR SUPERVISION OF PHYSICIAN? | DATE OF LAST PHYSICAL/MEDICAL EXAMINATION |
| NAME OF PHYSICIAN | FAMILY MEDICAL HOSPITAL |
| DOES CHILD USE ANY SPECIAL DEVICE(S): | IF YES, WHAT KIND? |
| INSURANCE CARRIER | GROUP #<br>MEMBER # |
| EMERGENCY CONTACT | PHONE NUMBER |
| EMERGENCY CONTACT – NOT LOCAL | PHONE NUMBER |
| **MY CHILD HAS THE FOLLOWING MEDICATION ALLERGIES** | |
| | |
| **LIST ANY ALLERGIES WE SHOULD BE AWARE OF** | |
| PARENT'S EVALUATION OF CHILD'S HEALTH | |

**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<br>Parent Initial _____ | | |
| **VARICELLA (CHICKENPOX, VAR, MMR-V, OR VZV)** | 1 dose<br>Parent Initial _____ | 1 dose for ages 7-12 years. 2 doses for ages 13 - 17 years.<br>Parent Initial _____ | |

Additional Emergency Contacts

| Name | Phone Number | Alternate Phone Number |
|---|---|---|
| Name | Phone Number | Alternate Phone Number |