girl scouts of california's central coast

Girl/Adult Health History Form

Please print clearly in ink.

☐ GIRL MEMBER ☐ ADULT MEMBER

CONTACT INFORMATION

Troop #: or Individual ☐	Service Unit:	
First Name:	Middle Name:	Last Name:
Mailing Address: Apt. #:		PO Box:
City:	State: Zip Code:	Phone:
Cell:	E-mail:	
Guardian/Adult(s) Name and address *(If different from girl's): (Complete for girl form only)* 1.		Phone: Cell:
Guardian/Adult (s) Name and address *(If different from girl's): (Complete for girl form only)* 2.		Phone: Cell:
Custodial Care Information: ☐ Both Parents ☐ One Parent (specify): _____ ☐ Other: _____		

HEALTH INFORMATION

Name of Family Physician:		Phone:
Family Medical/Hospital Insurance Carrier:		Policy or Group No:
Family Dental Insurance Carrier:		Policy or Group No:

Health Information: Age: Date of Birth: ☐Immunizations are up to date in accordance with Health and Safety Code 120335

Date of last Tetanus shot:

Date of last health examination: Were there any medical problems at the time?

Does participant have any physical, mental or psychological conditions requiring medication, treatment, or other special restrictions or considerations?

☐ Yes ☐ No If yes, please state medication and reason:

Does participant take any prescribed medications or over-the-counter drugs on a regular basis?

☐ Yes ☐ No If yes, please state medication and reason:

Is participant restricted or limited from participating in any physical activity?

☐ Yes ☐ No If yes, please explain:

Please provide a record of past medical treatment, if any, including injures or surgeries:

Participant has the following health conditions/allergies/dietary restrictions (food and medications):

☐ ADHD ☐ Asthma ☐ Diabetes ☐ Headaches ☐ Seizures ☐ Other: _____

☐ Allergies (specify):

Emergency Contact (non-parent):		
Relationship:	Phone:	Cell:

AUTHORIZATION

GUARDIAN/ADULT AUTHORIZATION

This health form is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my Girl Scout should not participate in the prescribed activities except as noted. In the event that my Girl Scout needs medical attention while participating in Girl Scout activities, I authorize the adult in charge to see that my Girl Scout receives routine healthcare, medications, reasonable first aid and to transport them to a health care facility for emergency services as needed.

Signature of guardian/adult: Date:

ADULT MEMBER AUTHORIZATION

This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.

Signature of adult member: Date:

Parent - Please retain a copy for day camp, resident, and other overnight camp programs.
Troop Leader – please retain for your records.