Personal Health and Medical Record Form ☐ Adult ☐ Girl Age ___ Gender (if adult)

girl scouts of north east ohio

Update annually for all participants
Activity: Troop meetings, over night trips, or other programs not exceeding 72 hours. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference. (Attach separate page if necessary). To be filled out by parent, guardian, or adult participant annually. Please print in ink.

Name _____ Troop _____ Date Completed _____

Participant Information

Name _____ Date of Birth ☐☐ ☐☐ ☐☐
(Last) (First) Mo Day Year

Address _____

City & State _____ Zip _____

Parent / Guardian Information

Girl is under custodial care of:
Both parents _____ Guardian(s) _____
Mother only _____ Father only _____

Parent/Guardian Name _____

Address
_____

Phone _____ (day)
_____ (evening)

Medical History

Date of most recent physical exam: _____
Are you aware of any current health problems? Yes / No
Now under medical care of taking medication? Yes / No
in the last 6 months – have any of these happened:
Any surgery, illness, allergy or other change? Yes / No
Hospitalizations or serious injuries? Yes / No
Give dates and full details for any "yes" answers here:
_____
_____

Current Medications _____
Being taken for (condition) _____
Dosage and frequency _____

Chronic or Recurring Conditions (check all that apply)

- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Convulsions / Seizures
- ☐ Diabetes
- ☐ Ear Infection
- ☐ Emotional / behavior disturbance
- ☐ Hypertension
- ☐ Heart disease / defect
- ☐ Urinary Infection
- ☐ Vision – Contacts / Glasses
- ☐ Teeth – dentures / bridge
- ☐ Menstrual problems
- ☐ Fainting
- ☐ Other

Please provide details for any items checked (attach separate page if necessary).
_____
_____

Special Needs
Dietary
_____
_____

Activities to be restricted _____
_____
_____

This Health History is complete and accurate. My daughter/I have permission to engage in all prescribed activities except as noted above.

Signature _____ **Date** _____
(Parent / guardian or adult)

Medical Authorization

I give permission for full participation in GSNEO programs. In the event that I and the other Emergency Contacts listed below cannot be contacted, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Signature _____ Date: _____
(Parent / guardian or adult)

Emergency Contact Information

In addition to the above parent(s)/guardian(s), this girl may be released to the following person(s):

Name: _____
Relationship: _____ Phone _____

Name: _____
Relationship: _____ Phone _____

Personal Physician
Name: _____ Phone _____
Insurance Carrier _____
Policy # _____ Phone _____
Insured name (parent) _____

Dentist
Name: _____ Phone _____
Insurance Carrier _____
Policy # _____ Phone _____
Insured name (parent) _____

Allergies (check all that apply)

- ☐ Animals
- ☐ Food(s)
- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Medicine/drugs
- ☐ Plants
- ☐ Pollen
- ☐ Other

Please provide details of any checked
(Attach separate page if necessary):
_____
_____

Immunizations (year)

- Tetanus _____
- Measles _____
- Rubella _____
- Mumps _____
- Diphtheria _____
- Pertussis _____
- Hepatitis B _____
- TB Test _____
- COVID-19 _____
- Other _____

Medical Authorization

I give permission for First Aider to administer to my daughter/ward/me, according to instructions printed on the original container, the following over-the-counter and/or prescription medications which I have provided in their original containers. Check all that apply:

- ☐ Acetaminophen (Tylenol)
- ☐ Antacid (Mylanta, Tums)
- ☐ Hydrocortisone cream
- ☐ Cough suppressant (Robitussin)
- ☐ Antibiotic cream (Neosporin)
- ☐ Calamine lotion
- ☐ Other
- ☐ Ibuprofen (Motrin)
- ☐ Oral anesthetic
- ☐ Antihistamine (Benadryl)
- ☐ Eye wash
- ☐ Sunscreen
- ☐ Insect repellent

Prescription medications (attach separate page if necessary): _____
_____
_____

Signature _____ **Date** _____
(Parent / guardian or adult)