Girl Permissions & Health History

To be completed and signed by parent/guardian of girls.

Section 1 - Health History
Section 2 – Prescription Medication
Section 3 – Extended Travel (3+ Days) Health History
Section 4 – Extended Travel (3+ Days) Physician Exam

Girl Full Name:	**Date of Birth:**	**Age:**
Address:		
Parent/Guardian Name:	**Phone:**	**Email:**
Physician's Name:	**Phone:**	
Emergency Contact:	**Phone:**	**Relationship:**

Pick up information - Name of person (s) permitted to pick up your child:	
Name	Phone number
Names of person (s) NOT permitted to pick up your child:	
If applicable can she walk home: Yes ☐ No ☐	

Medical History - Check all that apply

	Arthritis		Fainting/dizzy spells		Musculoskeletal Disorders
	Asthma		Headaches/Migraines		Mental/Psychological Disorders
	Bedwetting		Hearing Impairment		Nosebleeds
	Bleeding disorder		Heart Defects/Disease		Sinusitis (Sinus Infections)
	Convulsions/Epilepsy/Seizures		Hernia		Sleep Disturbances
	Diabetes		Hypertension/High Blood Pressure		Sleep Impairment
	Diseases of the Ear or Ear Infections		Intestinal Disorders/Constipation		Speech Impairment
	Eating Disorders		Kidney/bladder illness		Had Surgery/Hospitalized in the last 5
	Eyesight Impairment		Menstruation has started		Under Physician/Psychologist care
			Menstrual cramps		Other:

Date of last health examination:	Were any complicating medical problems noted in last health exam __Yes __No
Please explain in detail any items checked above:	
My child's immunizations are update in accordance with state of Washington requirements for public schools ___ Yes ___No If not, state reason(s):____ DTP or DT (Tetanus) Date:_______________	

Health Insurance Information - In case of accident or illness, personal insurance is primary, Girl Scout insurance is secondary

Policy Holder Name		Insurance Company	
Policy Number		Insurance Company Address	
Group Number		Insurance Company Phone Number	

Girl Name _________________________

Allergies - List ALL allergies (including medications, food, bees, etc.), the type of reaction/severity, treatment and date of last reaction.

Allergies	Reaction/Severity	Treatment	Date of Last Reaction

Comments:

Does your child suffer from Anaphylaxis?* Yes ☐ No ☐

*A severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Does she carry an Epipen? Yes ☐ No ☐ Does she carry an inhaler? Yes ☐ No ☐

Over the Counter Medications & Dietary Restrictions

	My child does not have permission to take over the counter medication (please include over the counter medication allergies above)
	My child can take the following over the counter medications daily or in case of accident/injury/sickness (for example pain reliever, digestive relief, etc.) Please include dosage as necessary.

Special consideration or notes:

My child has the following dietary restrictions:

My child takes prescription medication: ___Yes ___No If yes complete Section 2 of this form: ___ Yes ___No

Signatures – Initial and Sign

	I understand that if my daughter is to have a ride home, I am responsible for seeing that the person I named above is there by ___________ p.m. to pick her up. (I understand that neither the volunteer nor Girl Scouts is responsible for driving her home or walking with her.
	I am the parent or guardian having legal custody of the child named above. I authorize all medical, surgical, diagnostic, and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital, when efforts to contact me are unsuccessful and when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment. I will take full responsibility for all charges that occur. Girl Scout insurance is secondary to your primary insurance.
	I know of no reason (s), other than the information indicated on this form, why my daughter should not participate in activities except as noted.
	For Troop - Throughout the year, there will be meetings and field trips held outside the normal meeting space. Your signature will give permission for all of our group's local activities, including any field trips of one day or less. You will be informed in writing at least one week in advance of each field trip so you can let the leader know if you do NOT want your daughter to participate. If the leader does not hear from you, she/he will assume based on your signature below that your daughter has your permission to participate. You will need to complete individual permission slips for any activities over one day.

Signature____ Date_____________

Girl Name___________________________

Section 2 – Prescription Medication Form – to be signed by physician and parent/guardian

Prescription Medication
List any medications including dosage schedule and specific instructions for use. ALL prescriptions must be in the original container with appropriate label. *If traveling please provide extra written prescription(s) from the doctor with the **generic name** for all medications in case the original prescription is lost or a new one needs to be obtained.*

Medical Condition	Medication	Dosage	Dosage instructions (When and How often)	Special Storage Requirements

Other:

Special considerations or notes

Parent/Guardian Signatures – Initial and Sign

I am the parent/legal guardian of _____________, a registered Girl Scout who has a medical condition that requires that she take prescription medication. Throughout the course of the year, she also may take over-the-counter medications as needed. Because I will be unable to be with her at the time she needs to take prescription I give ______________[name of troop leader or authorized volunteer] permission to administer the following medication to my daughter or legal ward according to the instructions of her medical provider:

I understand I am responsible for assuring that all medications I give to the volunteer are not expired. I further understand that the troop leader or volunteer helping me in this regard is not required to undertake this responsibility, and that he or she may discontinue doing so upon giving notice to the Girl Scouts of Western Washington and me.

I have reviewed the Girl Scouts of Western Washington policy on administering medication to a minor

Signature____ Date____________

Printed Name________________________ Phone Number_________________
Email____________________________

Medical Provider Signatures – Written authorization and instruction from medical provider regarding administering medications

I am familiar with the medication condition of_________________________ [name of Girl Scout], who is a patient of_______________________ [name of office or clinic]. I understand that the purpose of this form is to allow a Girl Scouts of Western Washington volunteer to administer medication to the above named girl, and believe that he or she should be able to follow the instructions listed below without any further training and without detriment to the Girl Scout.
_____________________ [name of Girl Scout] has the condition(s) set forth above that require that she take medication that has been prescribed by this clinic or by me. The volunteer who administers the medication should keep it in its original, marked container, should store it out of reach of other children, and should give the Girl Scout the medication in the dosage and according to the schedule set forth above.

Are there any OTC medications that are contraindicated for this Girl Scout? ___ Yes ___No
If yes, please list:

If the volunteer has any questions or observes the Girl Scout having any of the following symptoms, the volunteer should contact this office or another qualified medical provider immediately.

Signature of Physician ____
Date_____________

Printed Name________________________
Phone Number____________________ Emergency Number____________________________

Girl Name___________________________

Section 3 – Extended Travel (3+ Day) Health Form – to be completed by parent/guardian

Secondary Emergency Contact			
Name		**Phone**	
Relationship		**Secondary Phone**	
Email			

Additional Medical History - Check all that child has had			
	Chicken Pox		Mumps
	German Measles		Rheumatic Fever
	Kidney Disease		Tuberculosis
	Measles		Other:
Please explain in detail any items checked above:			
Has your girl had any adverse reactions to general anesthetics? Yes/No			
Any other information not covered in this form that is important that advisors for this trip should know about – Use additional sheet if necessary?			

Medical Conditions and/or Concerns Please include any precautions or restrictions on activities, as well as concerns relating to emotional and mental well-being (including self-harm, depression, effects of medication on their behavior, eating disorders, etc.). We want to provide the most supportive environment possible, and a large part of that is knows what's going on with trip participants. The more information you provide, the better we can to work with you to establish a plan.	
Name of Condition	Effects
Additional Information or Comments:	
Has your girl had any adverse reactions to general anesthetics? Yes/No	

Girl Name__________________________

Section 4 – Extended Travel (3+Day) Health Examination Form – to be completed by Physician

Trip Information - Must be completed by Parent/Guardian	
Trip/Activity:	
Region/Location:	Date Range of Trip/Activity:
Distance from Emergency Medical Services:	Level of First Aid Required:
Trip/Activity Description: Include a brief description of your trip. This will help the medical professional evaluate your physical readiness for the trip. Please note if different activities will be done (ex. rock climbing, cultural sites, etc.)	

Record of Immunization - Complete in detail or attach documentation

Immunization	Date Series Completed	Year of Last Booster	Immunization	Date Series Completed	Year of Last Booster
Hepatitis B			Hepatitis A		
Diphtheria, Tetanus, Pertussis (DTap/Tdap)			Inactivated Poliovirus (IPV)		
Measles, Mumps, Rubella MMR)			Influenza		
Rotavirus (RV)			Varicella		
Haemophilus influenzae type b (Hib)			Meningococcal (MCV)		
Pneumococcal (PCV)			Human Papillomavirus (HPV)		
IPV/OPV			Typhoid		
Paratyphoid			Cholera		
Yellow Fever			Typhus		
Rocky Mountain			Spotted Fever		
Rota			Other		
Tuberculin Test: Year last given:_______________ Results:__________________					

Medical Examination Form - Must be completed by a licensed physician, nurse practitioner, physician assistant or registered nurse within the preceding 12-24 months, unless a health issue is present.

Height:	Weights:	Blood pressure: ______/________	Pulse Rate:
Hearing: R_________ L________	Eyes: With Glasses R 20/_____ L20/_____	Without Glasses R 20/_____ L20/_____	

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

	Nose		Lungs		Urinalysis		Musculoskeletal
	Throat		Abdomen		HGB		General Physical State
	Teeth		Hernia		Skin		General Emotional State
	Heart		Genitalia		Appearance/Nutrition		Other

Licensed Physician Name:___________________________________ State License Number:__________________________
Phone Number:_________________
Address:________________________ City:_________________ St:_________________ Zip:________________

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted. Yes/No

Signature of Licensed Physician:____Date: ________________________