girl scouts of nassau county

# Girl Health History

This form must be completed and returned to council staff prior to attending the first program meeting.

Child's Name

Address | City | State | Zip

Date of Birth | Age | School | Grade | Troop Number

## PARENT/GUARDIAN INFORMATION

Child is in the custodial care of: ❑ Both Parents ❑ Mother Only ❑ Father Only ❑ Other: _____

Parent/Guardian 1 | Address (if different than child's)

Phone 1 | Phone 2 | Phone 3 | E-mail

Parent/Guardian 2 | Address (if different than child's)

Phone 1 | Phone 2 | Phone 3 | E-mail

## EMERGENCY CONTACTS

Name | Relationship | Phone 1 | Phone 2 | Phone 3

Name | Relationship | Phone 1 | Phone 2 | Phone 3

## HEALTH INFORMATION (Check all that apply and provide requested information)

| **Allergies** | **Yes** | **No** | **Explain "yes" answers.** *Include the type of allergy(e.g. "nut allergy" in the food category)* |
|---|---|---|---|
| Animals | ❑ | ❑ | |
| Insect Stings | ❑ | ❑ | |
| Plants/Trees | ❑ | ❑ | |
| Food | ❑ | ❑ | |
| Drugs | ❑ | ❑ | |
| Other | ❑ | ❑ | |

**Explain any specific needs or accommodations required:**

*Continued>*

## MEDICAL CARE AND INSURANCE INFORMATION

Physician _____ Phone _____

Preferred Medical Facility _____

Address: _____

Insurance Company _____ Policy#: _____

Policy Holder _____

Company Address _____ City _____ State _____ Zip _____

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First-Aider or Adult-In-Charge to provide routine first aid. This authorization extends to my child's participation in any activity sponsored by Girl Scouts of the USA, Girl Scouts of Nassau County or individual units. Should a medical emergency arise during my child's participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Signature _____ Date _____

* lf for any reason you can not sign this form, please attach a written statement to this form.
The statement must be signed for attendance/participation.