girl scouts
greater los angeles

20__- 20__

HEALTH INFORMATION AND RELEASE FORM

To be completed and reviewed annually by parent/caregiver. This form is to be kept with the troop/group records and accompany the troop/group leader on all troop/group activities. It is designed to provide the troop/group leader with the information needed to access medical care for your girl. It should be reviewed and updated (as needed) when information changes.

Name:_____ Date of Birth:_____ Phone #: _____

Address:_____

City:_____ State:_____ Zip:_____ Troop/Group #: _____

PART I: PARENT/CAREGIVER INFORMATION AND RELEASE

The above Girl Scout is under the custodial care of:

_____ Both Parents _____ Mother only _____ Father only _____ Caregiver(s) (specify) _____

Mother/Caregiver Name:_____

Address (if different than girl):_____

Phone (day): _____ Phone (evening):_____

Cell Phone:_____ Email:_____

Father/Caregiver Name: _____

Address (if different than girl):_____

Phone (day):_____ Phone (evening):_____

Cell Phone:_____ Email:_____

PART II: EMERGENCY CONTACT AND RELEASE INFORMATION

In the event that I cannot be reached in an emergency, the following are authorized to act in my behalf:

Name:_____ Relationship to Girl: _____

Cell Phone:_____ Other Phone:_____

Name:_____ Relationship to Girl:_____

Cell Phone:_____ Other Phone:_____

PART III: HEALTH CARE INFORMATION:

Physician's Name:_____ Phone:_____

Dentist's Name:_____ Phone:_____

Is the girl covered by family medical/hospital insurance? ❑ Yes ❑ No

If so, carrier or plan name:_____ Policy or Group #:_____

Name of insured:_____ Relationship to girl: _____

MEDICAL HISTORY (check those that apply)				
❑ Asthma Provoked by: _____ ❑ Has Prescribed Inhaler	❑ Diabetes ❑ Epilepsy	❑ Fainting ❑ Lactose Intolerant ❑ Medical Tags/Devices	❑ Nosebleeds ❑ Seizures ❑ Skin Condition	❑ Hearing Impairment ❑ Vision Impairment ❑ Wears Contact Lenses
Additional health information including **disabilities and/or special needs** (medical, physical, emotional, etc...) Please Specify:				

IMMUNIZATION HISTORY (check those that apply)	
❑ Tetanus (within past 10 years) Date: _____	❑ Immunization Records Are Up-To-Date ❑ N/A

ALLERGY HISTORY (check those that apply)				
❑ Animals ❑ Chlorine (pool)	❑ Hay Fever ❑ Other _____	❑ Insect Stings _____	❑ Plants/Pollen _____	❑ Medicine/Drugs _____

FOOD: Please list all that we should be aware of.
Indicate if **Intolerant (I) or Allergic (A).** Ex. Strawberries **A** , Milk **I**

❑ Corn _____ ❑ Dairy _____ ❑ Eggs _____ ❑ Fish _____ ❑ Food Coloring _____	❑ Gluten/Wheat _____ ❑ Peanuts _____ ❑ Shellfish _____ ❑ Soy _____ ❑ Tree nuts _____	Other Food Allergies Aware Of: ❑ Fruits/Veggies _____ _____ _____
❑ Inhaler or Epinephrine Used (will add to Medicine form)		❑ **Dietary special needs** _____

If any allergy box was checked, please indicate what the reaction is. Such as: strawberries/rash, milk/cramps, etc.

PART IV: MEDICATION (For day outings or overnights only.)
Over-the-counter medication, such as sunscreen, insect repellent, pain relievers, antibiotic ointment, antiseptic wipes, etc. cannot be administered by Girl Scout Leaders unless the Over-the-Counter (OTC) Form is completed and signed by a parent/caregiver. Also, if a Girl Scout is required to carry or regularly receive prescription or over-the-counter medications (including Epi-Pens and Inhalers) that will be provided by a parent/caregiver, that must be noted on the Provided Prescription and/or Provided OTC Medication Form as well.

- ❑ Permission Granted (see attached OTC/Rx Permission Form)
- ❑ Permission Not Granted (no form attached)

PART V: EMERGENCY MEDICAL AUTHORIZATION: In the event of an emergency, every effort will be made to contact a parent/caregiver or emergency contact. I hereby give authorization to Girl Scouts of Greater Los Angeles to seek treatment for my child and/or dependent minor by a licensed physician pursuant to California Family Code Section 6910 and California Civil Code Section 25.8. I know of no reason(s) why my girl may not participate in prescribed activities except as noted on this Health History Form. If permission for emergency medical treatment is not given, I will prepare a signed statement providing the reason, a release of liability, and alternate instructions and attach to this form.

Signature of Parent/Caregiver:_____ Date: _____

Signature of Parent/Caregiver:_____ Date: _____

❑ **I do not consent to the care or treatment set forth herein. Describe in detail what is/is not allowed/permitted:**

_____