GIRL HEALTH HISTORY

council emergency # (602) 531-5935

Girl Scout ______________________________

Address ______________________________

Phone ______________ Alt Phone ______________

Troop Leader ______________ Troop# ________

Parent/Guardian ______________________________

If the parent/guardian cannot be reached, the following person is authorized to act on their behalf:

Name ______________________________

Phone ______________ Alt Phone ______________

Address ______________________________

City ______________ State/Zip ______________

I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted. **If I cannot be reached in the event of any emergency, the troop leadership may act on my behalf by providing for emergency medical treatment and/or transportation.**

______________________________ ____________

Signature of Parent/Guardian **Date**

Please note any health condition or concern that should be considered in her activities.

- _____ Asthma
- _____ Diabetes
- _____ Convulsions
- _____ Heart Disease
- _____ Glasses/Contact Lenses
- _____ Kidney/Bladder Problems

Other: ______________________________

Other: ______________________________

Allergies **(Please Specify)**

- ☐ Animals ______________________________
- ☐ Medicine/Drugs ______________________________
- ☐ Foods ______________________________
- ☐ Hay Fever ______________________________
- ☐ Insects Stings ______________________________
- ☐ Other ______________________________

The following information is commonly requested by the emergency treatment facility:

Date of Birth ____ /____/ ____

Approximate Date of Last Tetanus Shot ____ /____

______________________________ ____________

Name of Doctor/Healthcare Provider **Phone**

______________________________ ____________

Name of Insurance Provider (if any) **Policy/Group #**

GIRL SCOUTS–ARIZONA CACTUS-PINE COUNCIL, INC.

GENERAL PERMISSION

______________________________ is **my/our** daughter or a girl in **my/our** legal custody. **I/we** have full authority to give this permission. She has **my/our** permission to participate in all Girl Scout program and activities conducted or sponsored by Troop # ________, to which she is registered, or which are conducted or sponsored by the Girl Scouts–Arizona Cactus-Pine Council, Inc.

In case of sickness or accident, **I/we**, give permission for medical attention and the administration of medication and treatment as prescribed by the girl's physician or as determined by an available physician, nurse, health professional or first aider.

☐ She needs or may need any of the following medications, i.e. inhaler, Epipen, dietary needs, or specific accommodations during her activity participation with her troop or individually: (Write "NONE" if there are none.)

____

☐ Physicians, nurses, health professionals or first aiders MAY NOT administer the following medicines or treatments:
(If there are no prohibitions or restrictions write "NONE".)

____

Signature of Parent/Guardian* **Date**

Address

Telephone **Alt Telephone**

E-mail

Signature of Parent/Guardian* **Date**

Address

Telephone **Alt Telephone**

E-mail

*Please see "Who Should Sign" on the information and instructions regarding Council Permission Slips.