

This form must be completed and signed by parents/guardians of girls or by adult members themselves. All Health History forms will be held in **limited access** by the **trustee** (leader/facilitator/staff) of the specific Girl Scout program. The **absolute minimal necessary information** may be shared with program staff/volunteers in order to provide adequate health care. The Health History form will be retained by the Girl Scout program **trustee** until it is destroyed.

# CONFIDENTIAL Health History



Girl Scouts of Greater Chicago  
and Northwest Indiana  
Lisle Regional Service Center  
2400 Ogden Ave., Suite 400  
Lisle, IL 60532-3933

## SECTION A: MEMBER INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Troop # \_\_\_\_\_

Address \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

If Parent/Guardian is unavailable, contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## SECTION B: HEALTH HISTORY/RECURRING CONDITIONS

Check each applicable item, giving appropriate dates and comments

### ALLERGIES / DESCRIPTION

- Foods \_\_\_\_\_
- Insects \_\_\_\_\_
- Plants \_\_\_\_\_
- Drugs \_\_\_\_\_
- Animals \_\_\_\_\_
- Hay fever \_\_\_\_\_
- Asthma \_\_\_\_\_
- Latex \_\_\_\_\_
- Other \_\_\_\_\_

### ADDITIONAL INFORMATION

- Operation/Date \_\_\_\_\_
- Serious injury/Date \_\_\_\_\_
- Sleepwalking \_\_\_\_\_
- Bedwetting \_\_\_\_\_
- Fainting \_\_\_\_\_
- Constipation \_\_\_\_\_
- Night Disturbances \_\_\_\_\_
- Other \_\_\_\_\_

### RECURRING CONDITIONS

- Ear Infections \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Kidney Ailment \_\_\_\_\_
- Convulsions \_\_\_\_\_
- Bronchitis \_\_\_\_\_
- Frequent Colds \_\_\_\_\_
- Frequent Sore Throat \_\_\_\_\_
- Stomach Upset \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Hyperactivity \_\_\_\_\_
- Epilepsy \_\_\_\_\_
- Hearing Impairment \_\_\_\_\_
- Vision Impairment \_\_\_\_\_
- Orthopedic Impairment \_\_\_\_\_
- Learning Disability \_\_\_\_\_
- Other \_\_\_\_\_

### DISEASES / DATES

- Chicken Pox \_\_\_\_\_
- Measles \_\_\_\_\_
- German Measles \_\_\_\_\_
- Mumps \_\_\_\_\_
- Scarlet Fever \_\_\_\_\_
- Rheumatic Fever \_\_\_\_\_
- Poliomyelitis \_\_\_\_\_
- Whooping Cough \_\_\_\_\_
- Other \_\_\_\_\_

DATE OF LAST HEALTH EXAMINATION: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Were any complicating medical problems noted? \_\_\_\_\_

Is participant now under the care of a physician/psychologist? \_\_\_\_\_

List restrictions to swimming, diving, running, etc. \_\_\_\_\_

Describe any medical/dietary regimen to be continued: \_\_\_\_\_

### SINCE LAST HEALTH EXAM, HAS THE PARTICIPANT HAD:

A serious illness requiring medical attention? \_\_\_\_\_

An illness lasting more than 5 days? \_\_\_\_\_

A surgical operation or fracture? \_\_\_\_\_

Treatment in a hospital or emergency room? \_\_\_\_\_

Any restrictions concerning physical activities? \_\_\_\_\_

Exposure to a contagious disease? \_\_\_\_\_ Within the past month? \_\_\_\_\_ What? \_\_\_\_\_

### IMMUNIZATIONS / DATES

- DPT \_\_\_\_\_
- Oral Polio \_\_\_\_\_
- Measles \_\_\_\_\_
- Td (Adult Tetanus) \_\_\_\_\_
- Mumps \_\_\_\_\_
- Rubella \_\_\_\_\_
- Tuberculin Test \_\_\_\_\_
- Tetanus \_\_\_\_\_
- Hib \_\_\_\_\_
- Hepatitis B \_\_\_\_\_
- Other \_\_\_\_\_

**THIS FORM MUST BE SIGNED  
DUPLICATE THIS FORM AS NEEDED**

## SECTION C: PARENT/GUARDIAN MUST COMPLETE THE INFORMATION BELOW

*I have read the above procedures for handling my/my daughter's health history information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. In case of emergency, I give permission for the First Aider(s) to administer medication, and/or First Aid AND give permission to an attending physician to hospitalize or secure proper treatment/surgery for me/my child. I give permission to transport me/my child to the nearest emergency facility for treatment. I know of no reason(s), other than the information indicated on this form, why I/my child should not participate in prescribed activities except as noted.*

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_