GIRL SCOUT COUNCIL OF ORANGE COUNTY

Health History

Troop #_____

Girls Name_____
Last First Middle Initial

Birth Date_____ Age_____

Custodial Parent/Guardian Name_____

Home Address_____ Phone_____
Number & Street City State Zip Area Code/Number

Business Address_____ Phone_____
Number & Street City State Zip Area Code/Number

If above contacts are not available in an emergency, notify:

Name_____ Relationship_____

Address_____ Phone_____
Number & Street City State Zip Area Code/Number

Name of family physician or Christian Science Practitioner_____ Phone_____
Area Code/Number

Do you carry family medical/hospital insurance? ☐ Yes ☐ No

Carrier Name_____ Policy or Group #_____

Carrier Address_____ Phone_____
Number & Street City State Zip Area Code/Number

Health History Information. If you check any of the boxes below, please explain below.

	Yes	No
Allergies:		
1. Hay Fever	☐	☐
2. Poison Oak, etc.	☐	☐
3. Insect Sting (i.e. bee, mosquito)	☐	☐
4. Penicillin	☐	☐
5. Asthma	☐	☐
6. Animals	☐	☐
7. Food	☐	☐
8. Drugs	☐	☐
Diseases:		
9. Chicken Pox	☐	☐
10. Measles	☐	☐
11. German Measles	☐	☐
12. Mumps	☐	☐
General Information:		
13. Had any recent injury, illness or infectious disease?	☐	☐
14. Have a chronic or recurring illness/condition?	☐	☐
15. Have frequent headaches?	☐	☐
16. Wear corrective eye wear?	☐	☐
17. Have a personal assistance device (e.g. wheelchair, brace, prosthetic device?	☐	☐
18. Have diabetes?	☐	☐
19. Have problem w/sleepwalking?	☐	☐
20. Have an eating disorder?	☐	☐
21. Have epilepsy?	☐	☐
Special Needs:		
22. Developmental Disability?	☐	☐
23. Hearing Impairment?	☐	☐
24. Visual Impairment?	☐	☐
25. Learning Disability?	☐	☐
26. Physical Impairment?	☐	☐

Please explain any "Yes", noting the number of the question:

_____

_____

_____

_____

List any restrictions in activities:_____

This health history is complete and accurate. My daughter has permission to engage in all activities, except as noted by me.

_____ _____
Signature of Parent/Guardian Date

I (we) the undersigned parent, parents or legal guardian of _____, a minor, do hereby authorize consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provision of the Medicine Practice on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render or which the aforementioned physician in the exercise of his/her judgment may deem advisable.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient but that any of the above treatments will not be withheld if the undersigned cannot be reached. I will not hold liable the Girl Scout Council of Orange County, its officers or leaders for medical aid rendered at a hospital or first aid rendered at the event and will reimburse the Girl Scout Council of Orange County for medical or other expenses incurred in the care of my daughter.

This authorization is given pursuant to Section-6910 of the Civil Code of California.

I will permit photographs of my daughter taken at this event to be used for publicity by authorization of the designated members of the Council.

Medication must be accompanied by written instructions from the parent or physician and in their original containers.

Parent/Guardian's Signature _____ Phone _____ Date _____

This consent shall remain effective for one year from this date: _____, 20_____.