girl scouts of the missouri heartland

Health History and Medication

Name _____

Date of Birth _____ Age _____ Phone _____

Address _____

City _____ State _____ Zip _____

Emergency Information

Primary Contact _____ Relationship _____

Home _____ Work _____ Cell _____

Secondary Contact _____ Relationship _____

Home _____ Work _____ Cell _____

Health Insurance Information

Name of Physician _____ Phone _____

Family Medical Center/Preferred Hospital _____

Policy Holder's Name _____ Policy Number _____

Insurance Company Name _____ Group Number _____

Insurance Company Phone _____

General Health History *(Check all that apply.)*

Diseases
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Measles
- ☐ Mumps
- ☐ Hepatitis A/B/C

Allergies
- ☐ Animals
- ☐ Foods
- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Medicines/Drugs
- ☐ Plants
- ☐ Pollen

Chronic or Recurring
- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Seizures
- ☐ Bleeding Disorders
- ☐ Asthma
- ☐ Hypertension
- ☐ Diabetes
- ☐ Mental Health or Cognitive Disorders
- ☐ Skin Problems / Rash

All General Health
- ☐ Other (Specify Below)

Please describe conditions and give dates. _____

_____

Please list operations or serious injuries. _____

Please list hospitalizations. _____

Please list other diseases/disabilities. _____

_____

Does the Girl Scout suffer from anaphylaxis? ☐ Yes ☐ No **If she has an anaphylactic allergy, include a copy of her allergy action plan. We cannot guarantee that any locations on trip are allergen-free.*

Does the Girl Scout carry an EpiPen? ☐ Yes ☐ No Does the Girl Scout carry an inhaler? ☐ Yes ☐ No

Comments or Suggestions from Parent/Guardian

Please comment where applicable.

Fainting _____ Sleep Disturbances _____

Bedwetting _____ Menstrual Cramps _____

Constipation _____ Nosebleeds _____

Mental/Emotional Health Challenges _____

Other _____

Adaptations and Restrictions

☐ I have reviewed the planned activities and feel the Girl Scout can participate without restrictions/adaptations.

☐ I have reviewed the planned activities and feel the Girl Scout can participate with the following restrictions/adaptations. *(Please describe below and speak with the chaperone.)*

_____

_____

Special medical or dietary regimen to be followed *(Please indicate any other activities that should be encouraged by staff.)* _____

_____

Record of Immunizations

Date of last health examination _____ Were there any medical problems noted? ☐ Yes ☐ No

If yes, please explain. _____

	Year Primary Series Completed	***Year of Last Booster***
DPT *(Diphtheria, Tetanus, Pertussis [Whooping Cough])*	_____	_____
Td	_____	_____
Oral Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hib	_____	_____
Hepatitis B	_____	_____
Other _____	_____	_____

Tuberculin Test Year last given _____ Result _____

Please Complete Medication Section on Next Page.

This health history is complete and accurate. My Girl Scout has permission to engage in all prescribed activities, except as noted by me. I understand the information on this form will be shared only with the trip chaperone and/or first aider. They will make every effort to protect personal health information and will only disclose such information to healthcare professionals providing treatment.

Signature of Parent/Guardian _____ Date _____

Medications ☐ ***This Girl Scout will not bring any medications on this trip.***

Include any medication the Girl Scout may need to take on this trip (including nonprescription drugs). All prescription medication must be in the original, labeled container. The label must contain: patient's name, physician's name, name of medication, dosage amount and administration, special instructions, pharmacy name and telephone, and prescription number. Prescription medications must have the full pharmacy label. Please bring an adequate supply; prescriptions cannot be filled or refilled for you. Over-the-counter medication must also be in the original container, clearly labeled, and marked with the girl's name and dosage instructions. *Attached additional pages if needed.*

Medication Name	Dosage	Time(s) Administered	Administration Instructions	Date Started	Reason for Taking

This Girl Scout has permission for the administration of the following medications if deemed necessary by a qualified first aider, nurse, or physician. Dosages with be administered per direction on the container unless otherwise directed by a physician.

Acetaminophen	☐Yes ☐No	Ibuprofen	☐Yes ☐No
Aloe Vera	☐Yes ☐No	Loperamide	☐Yes ☐No
Antacids	☐Yes ☐No	Magnesium Hydroxide	☐Yes ☐No
Antihistamine	☐Yes ☐No	Midol/Pamprin	☐Yes ☐No
Aspirin	☐Yes ☐No	Naproxen Sodium	☐Yes ☐No
Benadryl	☐Yes ☐No	Nasal Drops	☐Yes ☐No
Bismuth Subsalicylate	☐Yes ☐No	Neosporin (Antibacterial Ointment)	☐Yes ☐No
Calamine Lotion	☐Yes ☐No	Pepto Bismol	☐Yes ☐No
Cold & Flu Medication	☐Yes ☐No	Phenylephrine	☐Yes ☐No
Cough Drops/Syrup	☐Yes ☐No	Pseudoephedrine	☐Yes ☐No
Dimenhydrinate	☐Yes ☐No	Saline Solution	☐Yes ☐No
Dramamine (Motion Sickness)	☐Yes ☐No	Sting E-Z	☐Yes ☐No
First Aid Ointment	☐Yes ☐No	Swimmers Ear Drops	☐Yes ☐No
Hydrocortisone Cream	☐Yes ☐No	Throat Lozenges	☐Yes ☐No

My Girl Scout should **not** be given the following medications or first aid applications: