GIRL SCOUTS SUSITNA COUNCIL

HEALTH HISTORY FORM

This health history is to be completed and signed by parents/guardians of girls and turn in with registration

Name: _____ Date of Birth: _____ Age:_____
Address: _____ Troop No.: _____
Parent/Guardian: _____ Phone: _____
Home Address: _____
Business Address: _____ Phone: _____

In Emergency Notify:

Name: _____ Relationship: _____
Address: _____ Phone: _____
Name of Family Physician: _____ Phone: _____
Family Medical Hospital: _____ Address: _____
Insurance Carrier: _____ Policy or Group No.: _____

Racial/Ethnic Information (optional – to assist us in serving our diverse community)

❍ American Indian/Alaskan native ❍ Asian or Pacific Islander ❍ Black ❍ White ❍ Multi-Racial ❍ Other

Part I: Illnesses and injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness

❍ Ear Infection ❍ Bleeding/Clotting Disorders ❍ Hypertension ❍ Asthma ❍ Heart Defect/Disease
❍ Musculoskeletal Disorders ❍ Seizures ❍ Diabetes ❍ Other (specify) _____

Date of last health examination: _____
Were any complicating medical problems noted in the last health examination? ❍ Yes ❍ No
Are you currently under the care of a physician or psychologist? ❍ Yes ❍ No
Since the last health exam, have you had:
a serious injury requiring medical attention? _____ an illness lasting more than 5 days? _____
any prescribed or over-the-counter medication? _____ a surgical operation or fracture? _____
treatment in a hospital or emergency room? _____ any restrictions concerning physical activities? _____
any exposure to a contagious disease? _____
Please explain any "yes" answers to the above questions. Include dates: _____

Part II: Allergies (Check those that apply and specify nature of allergic reaction.)

__ Animals _____ __ Hay Fever _____
__ Pollen _____ __ Food _____
__ Plants _____ __ Insect Bites _____
__ Medicines/ Drugs _____
__ Other (Specify) _____

Part III: Other health conditions (Check those that apply)

__ Bed Wetting
__ Constipation
__ Menstrual Cramps
__ Motion sickness
__ Noesbleeds
__ Sleep disturbances
__ Other (specify) _____
__ Emotional Disorders
__ Fainting
__ Hearing impairment
__ Sickle cell trait or disease
__ Special dietary regimen
__ Wears glasses or contact lenses

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P.	_____	_____
Diptheria		_____
Pertussis (whooping cough)		_____
Tetanus	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella (Ger. Measles)	_____	_____
Oral polio	_____	_____
Hbpv	_____	_____
Tuberculin test (most recent) result		_____

Other: _____

Please explain any items that are checked. Indicate any information useful to the person in charge in relation to any of these health conditions. Also, indicate any activities to be restricted.

_____.

PARENT CONSENT: In the event of an emergency, every effort will be made to contact a person or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts Susitna Council to see treatment for my child or myself by a licensed physician.

Signature of parent/guardian: _____ Date: _____