GIRL SCOUTS OF GENESEE VALLEY, INC.
PARENT/GUARDIAN CONSENT, PHOTO RELEASE & HEALTH HISTORY FORM

FILL OUT COMPLETELY AND RETURN TO YOUR DAUGHTER'S TROOP LEADER. PLEASE PRINT.

Girl's Name: _____ Birth date: _____

Girl's Address: _____ Phone #: _____
Street City State Zip

Mother's/Guardian's Name: _____ Phone #: Day _____

Address: _____ Phone #: Evening _____
Street (If different from above) City State Zip

Father's/Guardian's Name: _____ Phone #: Day _____

Address: _____ Phone #: Evening _____
Street (If different from above) City State Zip

In case of emergency, person to notify if parent/guardian cannot be reached:

Name: _____

Relationship to girl: _____ Phone #: Day _____

Evening _____

PHOTO RELEASE AND CONSENT TO JOIN GIRL SCOUTS
My daughter/ward may be included in photographs taken during troop/group or council-wide activities. Girl Scouts of Genesee Valley may use these photographs for promotional purposes only.

____ Yes ____ No

HEALTH HISTORY RECORD (This health history is to be completed and signed by parent/guardian of the girl)

Name of Family Physician: _____ Phone #: _____

Family medical/hospital insurance carrier: _____

Policy or group number: _____

Date of last health examination: _____ Were any complicating medical problems noted in last health examination?

Yes ___ No ___ If yes, please explain:

-OVER-

PLEASE EXPLAIN ANY AREAS IN PARTS I-IV THAT ARE CHECKED. INDICATE ANY INFORMATION USEFUL TO THE ADULT IN CHARGE THAT WILL ENHANCE YOUR DAUGHTER'S TIME IN GIRL SCOUT ACTIVITIES.

Part I: ILLNESS AND CHRONIC OR RECURRING INJURIES (please check those that apply and give appropriate dates)

[ ] Asthma [ ] Bleeding/Clotting Disorders [ ] Constipation
[ ] Diabetes [ ] Ear infection [ ] Fainting
[ ] Nosebleeds [ ] Heart Defect Disease [ ] Seizure Disorder
[ ] Other (specify):

Part II: Medications (presently taking): _____

Part III: ALLERGIES *(check those that apply and specify nature of allergic reaction)

[ ] Animals [ ] Hay Fever [ ] Pollen [ ] Food
[ ] Insect sting [ ] Medicines/drugs [ ] Plants
[ ] Other (specify):

Part IV: OTHER CONDITIONS (check those that apply)

[ ] Attention Deficit Disorder [ ] Attention Deficit/Hyperactive Disorder
[ ] Bed Wetting/Sleep Disturbances [ ] Hearing Disability [ ] Learning Disabilities
[ ] Menstrual Cramps [ ] Mobility [ ] Motion Sickness
[ ] Sight/Vision Disability [ ] Special Dietary Needs
[ ]Other (specify):

Part V: IMMUNIZATION HISTORY (Please complete this section in detail, give approximate dates)

Immunization	**Month & Year Primary Series Completed**	**Month & Year of Last Booster**
D.T.P. [Diphtheria, Tetanus, Pertussis (Whooping Cough)]	_____	_____
Td (Adult tetanus diphtheria)	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella (German Measles)	_____	_____
Oral Polio	_____	_____
Hib (Haemophilius influenza B)	_____	_____
Tuberculin Test	(Most Recent) _____	Result_____
Other	_____	_____

This health history is complete and accurate. My daughter/ward has my permission to engage in all prescribed activities, except as noted. I give consent for my daughter to be a Girl Scout.

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Initials & Date Updated: _____ _____ _____

Form 2025
ljr -6/96