

# Girl Scouts Heart of the Hudson, Inc.

## Health History and Medical Examination Form for Minors

**Health History:** The more complete information you provide, the better we are able to work with your child to ensure she receives the care she needs.

**Medical Examination:** A medical examination is completed for trips lasting more than three nights. The examination is completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months unless a health issue is present.

Please type or write clearly and legibly.

<b>Name of Minor:</b> (Last, First, Middle Initial)	<b>Date of Birth:</b> (XX/XX/XXXX)		
<b>Address:</b>	<b>City:</b>	<b>St:</b>	<b>Zip:</b>
<b>Parent or Guardian:</b>	<b>Phone:</b>	<b>Alternate Phone:</b>	
<b>Parent or Guardian:</b>	<b>Phone:</b>	<b>Alternate Phone:</b>	

**Emergency Contact Information (parent/guardian):**

<b>Emergency Contact:</b>	<b>Relationship:</b>
<b>Phone:</b>	<b>Alternate Phone:</b>

**Health Insurance Information** (Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)

<b>Policy Holder's Name:</b>	<b>Policy Number:</b>
<b>Insurance Company Name:</b>	<b>Group Number:</b>
<b>Insurance Company Address:</b>	<b>Insurance Company Phone:</b>

**Check all that apply and explain in detail checked answers:**

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Sleep disturbances
<input type="checkbox"/>	Heart Defects/Disease	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Bed wetting
<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Musculoskeletal Disorders	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Convulsions/Epilepsy/Seizures	<input type="checkbox"/>	Measles
<input type="checkbox"/>	Sinusitis (Sinus Infections)	<input type="checkbox"/>	German Measles
<input type="checkbox"/>	Physical Restrictions	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Kidney/bladder illness	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Mental/psychological disorder	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Eating Disorders (Anorexia, Bulimia, etc.)
<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Headaches/Migraines
<input type="checkbox"/>	Has begun menstruation	<input type="checkbox"/>	Had surgery or hospitalized in the last 5 years
<input type="checkbox"/>	Menstrual cramps	<input type="checkbox"/>	Currently under doctor's care
<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	Emotional – Separation Anxiety
<input type="checkbox"/>	Other:		

**Please explain in detail all checked answers marked above:**

**Girl Name:** \_\_\_\_\_

**Allergies:** Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Does your daughter suffer from Anaphylaxis?    Yes    No

\*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Does your daughter carry an EpiPen?            Yes    No

Does your daughter carry an inhaler?         Yes    No

**Medical Conditions** (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

**Medications:** List any medications she is currently taken (or has taken in the recent past) including dosage schedule and specific instructions for use. Also, please indicate (Yes/No) if minor is allowed to take the medication on her own or if she should be monitored by an advisor. This would include any type of birth control.

Medication	Purpose	Dosage Schedule	Specific Instructions	Self-Medicate? (Yes/No)
1.				
2.				
3.				
4.				
5.				

**Over-the-Counter Medications:** My daughter has permission to take over-the-counter medications in case of accident or injury. Please check all that she has permission to take:

- |  |  |
|--|--|
| <input type="checkbox"/> Tylenol/Acetaminophen     | <input type="checkbox"/> Imodium (anti-diarrhea)   |
| <input type="checkbox"/> Aspirin (fever reducer)   | <input type="checkbox"/> Dramamine (motion sickness prevention)                                |
| <input type="checkbox"/> Ibuprofen (pain/swelling) | <input type="checkbox"/> Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.) |
| <input type="checkbox"/> Benadryl/Antihistamine    | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Robitussin/expectorant    | _____  |
| <input type="checkbox"/> Sudafed/decongestant      | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Pepto Bismol              | _____  |
| <input type="checkbox"/> Tums/antacid              | _____  |

**Special considerations or notes regarding over-the-counter medications:**

**Does your child have a Special Medical or Dietary Regiment to be followed?**    Yes    No

If so, please explain: \_\_\_\_\_

**Have you ever had any adverse reactions to general anesthetics?**    Yes    No

If so, please explain: \_\_\_\_\_

**Any other information not covered in this form that is important that advisors for this trip know:** \_\_\_\_\_

\_\_\_\_\_

**Girl Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (This section is to be completed by a physician after the review of health history with parent/guardian. Parent/Guardian must complete all the information of the Health History to the best of their knowledge and sign before meeting with licensed professional.)

**Medical Examination – Must be completed in detail.**

Height: _____	Weight: _____	B. P.: _____/_____	Hearing: R ___ L ___	
Eyes: With Glasses R 20/_____	L 20/_____	Without Glasses R 20/_____	L 20/_____	
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined				
_____ Nose	_____ Abdomen	_____ Urinalysis*	Other: _____	
_____ Throat	_____ Hernia	_____ HGB*	_____	
_____ Teeth	_____ Genitalia	_____ Appearance/Nutrition	_____	
_____ Heart	_____ Skin	_____ General Physical State	_____	
_____ Lungs	_____ Musculoskeletal	_____ General Emotional State	_____	

\*Girls should have this test if she had not had it since entering puberty.

**Record of Immunization – Must be completed in detail.**

	Date Series was Completed	Year of Last Booster		Date Series was Completed	Year of Last Booster
Hep B	_____	_____	Typhoid	_____	_____
DTap/Tdap	_____	_____	Paratyphoid	_____	_____
DT/Td	_____	_____	Cholera	_____	_____
Hib	_____	_____	Yellow Fever	_____	_____
IPV/OPV	_____	_____	Typhus	_____	_____
PCV7	_____	_____	Rocky Mountain	_____	_____
MMR	_____	_____	Spotted Fever	_____	_____
Varicella	_____	_____	Tuberculin Test: Year last given	_____	Result _____
Other:			Not required immunizations, but recommended		
_____	_____	_____	HPV	_____	_____
_____	_____	_____	Rota	_____	_____
_____	_____	_____	MCV4/MPSV4	_____	_____
_____	_____	_____	Hep A	_____	_____
_____	_____	_____	TIV/LAIV	_____	_____

Personal and religious beliefs dictate against immunizations: Yes No

**Physician Information**

<b>Licensed Physician Name:</b> (Last, First, Middle Initial)	<b>Phone Number:</b>		
<b>Address:</b>	<b>City:</b>	<b>St:</b>	<b>Zip:</b>

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

**Signature of Licensed Physician:** \_\_\_\_\_ **State License Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HEALTH INFORMATION PRIVACY STATEMENT**

The **Health History and Medical Examination Form for Minors** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

**This Health History and Medical Examination Form for Minors is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.**

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_