

Girl Scouts of Citrus Council, Inc.
GSUSA GIRL HEALTH HISTORY

This part to be filled in by parent.

Name (Last, First, Initial)		Parent or Guardian			Phone(s)	
					() ()	
Address	City or Town	State	Zip	Birth	Age	Sex
In Emergency Notify		Address			Phone (s)	
					() ()	

Health History: (Check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions From Parent:
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> German Measles <input type="checkbox"/> Kidney <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Animals _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Hay Fever _____ <input type="checkbox"/> Insect Stings _____ <input type="checkbox"/> Medicine/Drugs _____ _____ <input type="checkbox"/> Plants _____ <input type="checkbox"/> Pollen _____ <input type="checkbox"/> Other (specify) _____ _____	<input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Lyme disease <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Seizures <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other _____	My daughter has permission to take or use the following: <input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Advil/Ibuprofen <input type="checkbox"/> Sudafed/decongestant <input type="checkbox"/> Benadryl/antihistamine <input type="checkbox"/> Pepto Bismol <input type="checkbox"/> Tums/antacid <input type="checkbox"/> Robitussin/expectorant

Please describe conditions and give dates:

Operations or serious injuries: _____

Hospitalizations: _____

Other diseases/disabilities: _____

Comment where applicable:

Fainting _____ Sleep disturbances _____

Bed wetting _____ Menstrual cramps _____

Constipation _____ Nosebleeds _____

Emotional disturbances _____ Other _____

Specific activities to be encouraged _____ Activities to be restricted _____

Special medical or dietary regimen to be followed (specify) _____

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me. **A health examination within the preceding 24 months is required for participation in a trip of more than three nights (page 39 – Safety-Wise).**

Signature of Parent/Guardian _____ **Date** _____

GSUSA Rev. Membership Services, 3/15/2004

**CAMP HEALTH SUPERVISOR WILL ATTACH NOTARIZED COPY OF THE
AUTHORIZATION FOR TREATMENT OF MINORS HERE.**

**THERE WILL NOT BE A NOTARY
PUBLIC AT CAMP.**

Please list all current medications being taken. Please include dosage and any potential harmful interactions.

Please list any known allergies and describe the reaction.

Please list any other health related information that you wish our staff to be aware of.
