girl scouts of citrus

Minor Health History and Medical Examination

The Minor Health History and Exam Combination Form pages are to be submitted as follows:

- **Health History:** These forms must be completed by the parent/guardian and submitted annually to the troop they are currently registered with. Additional copies may be required for other events or overnight activities. In addition, if any changes need to make an update, please give an updated copy to the troop. The parent/guardian of the minor listed on these forms must complete and sign pages 1 & 2.
- **Medical Examination:** A Medical Examination and Health History are to be completed for trips lasting three nights or more and/or as required by council. Please review Volunteer Essentials & Safety Activity Checkpoints for details. The physical examination is to be completed by a licensed physician, nurse practitioner, physician's assistant, or registered nurse within the preceding 12 months unless a health issue is present. The parent/guardian of the minor listed on these forms must complete and sign pages 1 - 3.

Name of Minor: (Last, First, Middle Initial)	**Date of Birth:**	**Sex Assigned at Birth** F ◯ M ◯	**Gender** F ◯ M ◯ NB ◯
Address:	**City:**	**St:**	**Zip:**
Spouse (if applicable):	**Phone:**	**Alternate Phone:**	

Parent/Guardian:	**Parent/Guardian**
Phone:	**Phone:**

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

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply and explain any additional information below:

☐	Diabetes	☐	Eyesight Impairment
☐	Heart Defects/Disease	☐	Hearing Impairment/Ear Infections
☐	Asthma or Hay Fever	☐	Speech Impairment
☐	Autism Spectrum Disorder (ASD)	☐	Intestinal Disorders/Constipation
☐	Musculoskeletal Disorders	☐	Chicken Pox, German Measles, Measles, Mumps
☐	Convulsions/Epilepsy/Seizures	☐	Hernia
☐	Sinusitis (Sinus Infections)	☐	Menstrual cramps
☐	Physical Restrictions	☐	Rheumatic Fever
☐	Kidney/bladder illness	☐	Tuberculosis
☐	ADD/ADHD	☐	Eating Disorders (Anorexia, Bulimia, etc.)
☐	Hypertension/Abnormal Blood Pressure	☐	Headaches/Migraines
☐	Arthritis	☐	Had surgery or hospitalized in the last 5 years
☐	Nosebleeds	☐	Currently under doctor's care
☐	Bleeding disorder	☐	Other:
☐	Kidney Disease	☐	

Additional Information or Other Medical Conditions that include restrictions on activities:

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____ **Date:** _____

Minor Health History and Medical Examination

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 the minor suffer from Anaphylaxis? ◯ Yes ◯ No
- Does the minor need to carry an Epi-Pen? ◯ Yes ◯ No
- Does the minor need to carry an inhaler? ◯ Yes ◯ No
- Does the minor have any Special Medical or Dietary Needs? ◯ Yes ◯ No
    - If so, please explain:_____
- Has the minor ever had any adverse reactions to general anesthetics? ◯ Yes ◯ No
    - If so, please explain:_____
- Any additional information that we should be made aware of: _____

Medications: "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. List any medications the minor is currently taking including dosage schedule and specific instructions for use. Use an additional sheet if necessary. All medications including OTC must be in original containers and turned into the designated health professional if available. Be sure to include enough of each medication to last the entire event.

Medication	Purpose	Dosage Schedule	Specific Instructions

OTC – Medications: In case of emergency or illness please check off all medications that can be given to the minor:

	OTC Medication Name		OTC Medication Name		OTC Medication Name
☐	Tylenol/Acetaminophen	☐	Pepto Bismol	☐	Skin Ointments – anti-itch/antibacterial
☐	Aspirin	☐	Tums/antacid	☐	Robitussin/expectorant
☐	Ibuprofen	☐	Cough Drops	☐	Sudafed/decongestant
☐	Benadryl/Antihistamine	☐	Imodium	☐	Other

Health Information Privacy Statement

The Minor Health History and/or Medical Examination Form is for health care concerns at the specified event only. All records will be managed 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. I understand the information on this form will be shared on a "need to know" basis to provide adequate participant safety and health care for the minor. This Health History/Examination Form is complete and accurately reflects the health status of the who it pertains to. In case of an emergency, I give permission to the designated medical staff to treat my child as necessary for both routine health care and in emergency situations. I also give my permission to secure proper treatment for my child at the hospital/urgent care if necessary. I give permission to photocopy this form. I have read the above procedures for managing this health and medical form and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____ **Date:** _____

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Medical Examination: This page (3) must be completed by a licensed professional as listed above, once they have reviewed the completed and signed Health History (pages 1 & 2).

Patient Name:	**Patient Date of Birth:**

Height		Nose		Musculoskeletal	
Weight		Throat		Appearance	
Pulse		Heart		General Physical State	
BP		Lungs		General Mental State	
Hearing		Skin		Other	
Eyes		Abdomen		Other	

Immunization Record	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, Tetanus, Pertussis (DTaP) or (TdaP)						
Tetanus Booster (Tdap) or (Td)						
Mumps, Measles, Rubella,(MMR)						
Polio (I P V)						
Haemophiles Influenzae Type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) Had chicken pox Date:						
Meningococcal Meningitis (MCV4)						
COVID 19						
Tuberculosis (TB) test	Date:	Negative ☐ Positive ☐				

Patient Acknowledgment of Non- Immunization

If the patient has not been fully immunized, please have their parent/guardian sign the following statement: I understand and accept the risks that may come from not being fully immunized and do not hold Girl Scouts of Citrus Council, or any related entities responsible.

Parent/Guardian Signature: _____ Date: _____

Does this patient have any physical limitations/conditions which might limit any activity for this event/trip? ◯Yes ◯ No
If yes, please explain:_____

Should they limit their participation in swimming or other strenuous activity? ◯ Yes ◯No
If yes, please explain: _____

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

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

Signature of Licensed Physician: _____State License Number: _____Date: _____