girl scouts of new mexico trails

# *Health History and Parent Permission Form*

**Full Name** _____ Nickname _____

Address _____
Street City State Zip

Birthday _____ Service Unit: _____ Troop # or Juliette: _____
Month / Day / Year

**Custodial Parent/Guardian:**

Name _____ Relationship _____

Phone: Day _____ Evening _____ Cell _____

Name _____ Relationship _____

Phone: Day _____ Evening _____ Cell _____

**Emergency Contact:**

Name _____ Relationship _____

Address _____
Street City State Zip

Phone: Day _____ Evening _____ Cell _____

| *Past Illness* | *Allergies* | *Allergic Reaction* | *Other* | *Behavioral/Learning* |
|---|---|---|---|---|
| ☐ Ear Problems | ☐ Hay Fever | | ☐ Fainting | ☐ ADHD |
| ☐ Convulsions | ☐ Insect Stings | | ☐ Contact Lenses | ☐ Autism Spectrum Disorder |
| ☐ Asthma | ☐ Drugs (Specify) | | ☐ Diabetes | ☐ Bipolar |
| ☐ Heart Disease | ☐ Food (Specify) | | ☐ Nosebleeds | ☐ Anxiety |
| ☐ _____ | ☐ _____ | | ☐ _____ | ☐ _____ |
| ☐ _____ | ☐ _____ | | ☐ _____ | ☐ _____ |
| ☐ _____ | ☐ _____ | | ☐ _____ | ☐ _____ |
| ☐ _____ | ☐ _____ | | ☐ _____ | ☐ _____ |
| ☐ _____ | ☐ _____ | | ☐ _____ | ☐ _____ |

Are immunizations current ☐ Yes No ☐

Participant is taking the following medications (include times, dosage and reason for taking): _____

_____

Been hospitalized? ☐ Yes ☐ No If yes, explain when and why

_____

Medical Insurance Company _____ Medical Insurance Policy # _____
Physician's Name _____ Physician's Phone _____
*Dentist Name* _____ *Dentist Phone* _____

| | |
|---|---|
| **Special Dietary Restrictions**<br>The following dietary restrictions apply to this individual: | Does not eat: (circle) red meat pork poultry eggs dairy seafood gluten<br>Other notes: |
| **Special Activity Restrictions**<br>Explain any restrictions to activity (i.e. what cannot be done, what adaptations or limitations are necessary) | |

**Permission for Basic Medical Treatment**

By checking off the following items, I (parent/guardian) hereby give permission for the Troop leader, event/camp staff, or appointed first aider to administer the marked over-the-counter medications or generic equivalents if the onsite health care personnel deems it to be necessary. Dosage will be administered according to directions on the product.

| | |
|---|---|
| ☐ Acetaminophen/Tylenol – Adult or Children (headache, menstrual cramps, muscle cramps, fever) | ☐ Ibuprofen – Adult or Children (headache, menstrual cramps, muscle cramps, fever, ear aches) |
| ☐ Tecnu/Rhullgel/Ivy Dry/Calamine lotion (poison ivy, bug bites) | ☐ Ludens Throat Drops/Cipacol lozenges/Chloraseptic (sore throat) |
| ☐ Children's Pepto-Bismol/Tums/Rolaids (upset stomach/diarrhea) | ☐ Benadryl – Adult or Children – liquid or lotion (insect bites, allergy symptoms, allergic reaction) |
| ☐ Triple Antibiotic Cream/Neosporin (skin abrasions/minor cuts & burns) | ☐ Talcum Powder/Baby Powder (skin irritations, heat rash) |
| ☐ Sudafed liquid or tablets (stuffy nose) | ☐ Robitussin DM (cough) |
| ☐ Claritin, Claritin D (allefgy symptoms) | ☐ Hydrocortisone cream (insect bites, sunburn) |
| ☐ Foille/Solarcaine/Aloe Vera Gel (sunburn) | ☐ Lamisil (athlete's foot) |
| ☐ Oatmal Bath – Aveeno or similar (poison ivy) | ☐ Epsom Salt (muscle strains, skin irritations) |
| ☐ Desitin (skin irritations, heat rash) | ☐ Hydrogen Peroxide (minor cuts, scrapes, burns) |
| ☐ Anbesol (tooth aches) | ☐ Campho-Phenique (cold sores, insect bites, sunburn) |

By signing below, I grant permission for my daughter to attend **ALL TROOP/GROUP ACTIVITIES** for the 2014-2015 Girl Scout Year. I understand that I may rescind this permission at any time.

_____ _____

Parent/Guardian Signature Date