

Personal Health and Medical Record Form

Adult Girl Age _____ Gender (if adult) _____



Update annually for all participants

Activity: Troop meetings, over night trips, or other programs not exceeding 72 hours. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference. (Attach separate page if necessary). To be filled out by parent, guardian, or adult participant annually. Please print in ink.

Participant Information

Name _____ Date of Birth _____

(Last) (First) Mo Day Year
Address _____
City & State _____ Zip _____

Parent / Guardian Information

Girl is under custodial care of:
Both parents _____ Guardian(s) _____
Mother only _____ Father only _____
Parent/Guardian Name _____
Address _____
Phone _____ (day)
_____ (evening)

Medical History

Date of most recent physical exam: _____
Are you aware of any current health problems? Yes / No
Now under medical care of taking medication? Yes / No
in the last 6 months – have any of these happened:
Any surgery, illness, allergy or other change? Yes / No
Hospitalizations or serious injuries? Yes / No
Give dates and full details for any “yes” answers here:

Current Medications

Being taken for (condition) _____
Dosage and frequency _____

Chronic or Recurring Conditions (check all that apply)

Asthma Heart disease / defect
 Bleeding Disorders Urinary Infection
 Convulsions / Seizures Vision – Contacts / Glasses
 Diabetes Teeth – dentures / bridge
 Ear Infection Menstrual problems
 Emotional / behavior disturbance Fainting
 Hypertension Other

Please provide details for any items checked (attach separate page if necessary).

Special Needs

Dietary _____

Activities to be restricted _____

This Health History is complete and accurate. My daughter/I have permission to engage in all prescribed activities except as noted above.

Signature _____ Date _____
(Parent / guardian or adult)

Medical Authorization

I give permission for full participation in GSNEO programs. In the event that I and the other Emergency Contacts listed below cannot be contacted, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Signature _____ Date: _____
(Parent / guardian or adult)

Emergency Contact Information

In addition to the above parent(s)/guardian(s), this girl may be released to the following person(s):

Name: _____

Relationship: _____ Phone _____

Name: _____

Relationship: _____ Phone _____

Personal Physician

Name: _____ Phone _____

Insurance Carrier _____

Policy # _____ Phone _____

Insured name (parent) _____

Dentist

Name: _____ Phone _____

Insurance Carrier _____

Policy # _____ Phone _____

Insured name (parent) _____

Allergies (check all that apply)

Animals Plants
 Food(s) Pollen
 Hay Fever Other
 Insect Stings
 Medicine/drugs

Please provide details of any checked (Attach separate page if necessary):

Immunizations (year)

Tetanus _____
Measles _____
Rubella _____
Mumps _____
Diphtheria _____
Pertussis _____
Hepatitis B _____
TB Test _____
COVID-19 _____
Other _____

Medical Authorization

I give permission for First Aider to administer to my daughter/ward/me, according to instructions printed on the original container, the following over-the-counter and/or prescription medications which I have provided in their original containers. Check all that apply:

Acetaminophen (Tylenol) Ibuprofen (Motrin)
 Antacid (Mylanta, Tums) Oral anesthetic
 Hydrocortisone cream Antihistamine (Benadryl)
 Cough suppressant (Robitussin) Eye wash
 Antibiotic cream (Neosporin) Sunscreen
 Calamine lotion Insect repellent
 Other

Prescription medications (attach separate page if necessary): _____

Signature _____ Date _____
(Parent / guardian or adult)

Name _____
Date Completed _____

Troop _____