

GENERAL PERMISSION AND HEALTH HISTORY

Troop # _____ Leader _____

Meeting Place _____ Meeting Day & Times _____

PLEASE COMPLETE BOTH SIDES OF FORM

GENERAL PERMISSIONS:

Written permission from parent or guardian is necessary for the following:

- participation in any activity throughout the troop year that takes place during the regular meeting time and at the regular meeting place
- use of photos of your daughter by Girl Scouts of Kentuckiana
- administration by troop leader of acetaminophen (Tylenol or similar product)

Please sign the form below and return to the troop leader. Cross out any section for which you withhold permission.

BLANKET PERMISSION

My daughter, _____, has permission to participate in the activities of
(name)

Troop # _____ which take place during the usual meeting time and the usual meeting place throughout the current troop year. I understand that the leaders will request additional written parent or guardian permission for all other troop activities.

The following people have my permission to pick up my daughter from her Girl Scout meeting:

Name	Relationship to Child
_____	_____
_____	_____
_____	_____

Signed _____ Phone# _____ Date _____
(Parent or Legal Guardian)

PERMISSION TO ADMINISTER ACETAMINOPHEN

I give permission for acetaminophen (Tylenol or other product) to be administered to my daughter, _____, in case of need.

Signed _____ Date _____
(Parent or Legal Guardian)

#27
5/02

(Please complete health history on reverse side)

GIRL & ADULT HEALTH HISTORY

To: Participant

The health of any child is primarily the responsibility of the parent/guardian. The Girl Scout organization strongly recommends annual health examinations, dental check-ups, and immunization against preventable diseases. The Girl Scout policy of health and safety implies a responsibility to the participants for their protection. It also implies the right of the organization to be assured, as far as possible, that the participants are physically able to take part in activities.

Date: _____ Troop # _____
 Member's Name: _____
 Address _____
 Street _____
 City _____ State _____ Zip _____
 Date of Birth: _____ Age _____

PARENT/GUARDIAN (if member is not an adult):

Name: _____
 Phone: (home) _____
 Business Address: _____
 Phone: (business) _____

FAMILY PHYSICIAN:

Name: _____
 Phone: _____

EMERGENCY CONTACT (in case parent cannot be reached):

Name: _____ Relationship _____
 Address: _____ Phone _____

INSURANCE

Carrier: _____
 Family Medical/Hospital Insurance _____
 Policy or Group No.: _____

LAST HEALTH EXAMINATION:

Date: _____ Were there any complicating medical problems noted at that time? _____

Specify: _____

Since last health examination, has the person had:

	(Yes)	(No)
- A serious injury requiring medical attention?	_____	_____
- An illness lasting more than five days?	_____	_____
- A surgical operation or fracture?	_____	_____
- Any prescribed or over-the-counter medication?	_____	_____
- Treatment in a hospital emergency room?	_____	_____
- Any restrictions concerning physical activities?	_____	_____

Please explain "yes" to above questions. _____

Is person currently under the care of a physician or psychologist? _____

Specify: _____

PART I Illness & Injuries (Check those that apply)

- | | |
|---------------------------------|----------------------------------|
| _____ Asthma | _____ Heart Disease/Defect |
| _____ Seizures | _____ Hypertension |
| _____ Diabetes | _____ Bleeding/Clotting Disorder |
| _____ Ear Infection | _____ Other (specify) _____ |
| _____ Musculoskeletal Disorders | |

PART II: Allergies (Check those that apply and specify nature)

- Animals _____
 Food _____
 Insect Sting _____
 Medicine/Drugs _____
 Plants _____
 Pollen _____
 Hay Fever _____
 Other _____
 Treatment Used _____

PART III: Immunization Year

Tuberculin Test:	_____ (year)	Results: _____
	<u>Primary Series</u>	<u>Booster</u>
	(year)	(year)
D.P.T.	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Polio	_____	_____
Rubella	_____	_____
Hib	_____	_____
Other:	_____	

PART IV: Other Health Conditions (Check those that apply)

- | | |
|------------------------------|---------------------------|
| _____ Bed Wetting | _____ Nosebleeds |
| _____ Constipation | _____ Sickle Cell Disease |
| _____ Emotional Disturbances | _____ Special Diet |
| _____ Fainting | _____ Contact Lenses |
| _____ Hearing Impairment | _____ Glasses |
| _____ Menstrual Cramps | _____ Sleep Disturbances |
| _____ Motion Sickness | _____ Other: _____ |

 Indicate any information that would be useful to the adult in charge regarding the above conditions. Also indicate any activities to be encouraged or restricted.

 I know of no reason(s), other than the information indicated on this form, why my child should not participate in prescribed activities except as noted.

Signature of Parent/Legal Guardian _____ Date _____

(Please complete general permissions on reverse side)