



GIRL HEALTH HISTORY-complete both sides

PERSONAL INFORMATION:

Girl's Name (Last, First, Middle Initial) _____
 Birthdate (mm/dd/yy) _____ Age _____
 Parent's/Gurardian's Name (Last, First, Middle Initial) _____
 Street Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Other Phone _____

IN CASE OF EMERGENCY NOTIFY:

Name (First and Last) _____ Relation _____
 Address _____ Phone _____

INSURANCE INFORMATION, PLEASE COMPLETE THE FOLLOWING:

Carrier _____ ID Number _____ Group Number _____
 Member Services Phone _____ Address _____

HEALTH HISTORY (CHECK THOSE THAT APPLY):

DISEASES	ALLERGIES	CHRONIC OR RECURRING ILLNESS	SUGGESTIONS FROM PARENT
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney	<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"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other _____	My daughter has permission to take or use the following, which I have supplied in original containers: <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/Antacids <input type="checkbox"/> Robitussin/Expectorant

PLEASE DESCRIBE CONDITIONS AND GIVE DATES:

Operations or serious injuries _____
 Hospitalizations _____
 Other diseases/disabilities _____

COMMENTS WHERE APPLICABLE:

Fainting _____ Sleep disturbances _____
 Bed wetting _____ Menstrual cramps _____
 Constipation _____ Nosebleeds _____
 Emotional disturbances _____ Other _____
 Specific activities to be encouraged _____ Restricted _____
 Special medical or dietary regimen to be followed (specify-see back) _____

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted.

Signature of Parent/Guardian _____ Date _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Girl Health History Record** is for health care concerns at the specified event only. All records will be handled 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 of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. Sybaquay Council will retain the health form until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but the participant or their legal representative may request copies from the event sponsor. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature of Parent/Guardian _____ Date _____

GIRL HEALTH HISTORY

GIRLS NAME: _____

Please list any medications your daughter (ward) will have with her:

Name of medicine	Prescription or nonprescription	Reason for taking	Dosage/ time	Liquid or pill	Needs refrigeration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List any special dietary restrictions: (Please notify us prior to camp.)

List any additional medical information we should be aware of:

Signature of Parent/Guardian _____ Date _____