girl scouts of kansas heartland

Girl Scouts of Kansas Heartland
Health History and Authorization Form

Section A and B: (personal information, health history, authorizations) is to be completed for all Girl Scout activities and turned in to a troop volunteer or program staff. Complete information is essential to provide the care the participant may need. This form is confidential and will be stored in a secure location; records will only be released to volunteers and program staff to provide adequate participant safety and health care during Girl Scout activities and as required for medical treatment, referral, billing or insurance purposes. The Health History and Authorization Form must be reviewed annually. When changes are necessary, complete a new form.

Section A) Personal Information: *Please type or write clearly and legibly.*

Participant's Name: (Last, First, Middle Initial)	**Date of Birth:** (XX/XX/XXXX)		
Address:	**City:**	**St:**	**Zip:**
If minor, Parent or Guardian:	**Phone:**	**Alternate Phone:**	
If minor, Parent or Guardian:	**Phone:**	**Alternate Phone:**	

Emergency Contact Information: *For minors, alternate contact in case parent/guardian cannot be reached.*

Emergency Contact:	**Relationship:**
Phone:	**Alternate Phone:**

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

Family Physician:	**Hospital Preference:**
Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Section B) Health History:

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 participant suffer from Anaphylaxis? Yes ☐ No ☐
Does the participant carry an Epipen? Yes ☐ No ☐
Does the participant carry an inhaler? Yes ☐ No ☐

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Participant's Name: _____

Medications: List any medications the participant is currently taking (or has taken in the recent past) including dosage schedule and specific instructions for use. No child shall keep medication in their possession; it must be turned in to the adult in charge in original packaging or prescription bottle with directions.

Medication	Purpose	Dosage Schedule	Specific Instructions
1.			
2.			
3.			

Over-the-Counter Medications: The participant has permission to take over-the-counter medications in case of accident or injury. Please check all that (s)he has permission to take:

- ☐ Tylenol/Acetaminophen
- ☐ Aspirin (fever reducer)
- ☐ Ibuprofen (pain/swelling)
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/expectorant
- ☐ Sudafed/decongestant
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Imodium (anti-diarrhea)
- ☐ Dramamine (motion sickness prevention)
- ☐ Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
- ☐ Other: _____
- ☐ Other: _____

Special considerations or notes regarding over-the-counter medications:

Does the participant have a Special Medical or Dietary Regiment to be followed? Yes ☐ No ☐
If so, please explain: _____

Has the participant ever had any adverse reactions to general anesthetics? Yes ☐ No ☐
If so, please explain: _____

List any other information not covered in this form that is important for troop volunteers or program staff to know:

_____

_____

WAIVER OF LIABILITY

With appreciation of the dangers and risks associated with programs and activities, on behalf of myself and on behalf of my participating child/dependent, I hereby fully and completely release and waive any and all claims for illness, personal injury, death or loss that may arise against the Girl Scouts of Kansas Heartland, Inc, the activity coordinators, and all employees, volunteers, related parties or other organizations associated with any program or activity. I understand the inherent risks of participation, including that of the spread of infectious disease such as Covid-19.

INITIAL HERE: _____

CONSENT TO MEDICAL TREATMENT:

I, _____, participant or parent/legal guardian of minor participant _____, do hereby consent to any hospital, medical, or surgical care and treatment, and the administration of anesthesia, determined by a qualified physician to be necessary for the welfare of myself or my child while said child is under the care, custody, and control of a Girl Scout adult, and I am not reasonably available by telephone to give consent. **INITIAL HERE:** _____

MEDIA PERMISSIONS

When participating in Girl Scout activities the participant or parent/guardian of minor participant gives consent to be interviewed, photographed, videotaped, or electronically imaged for the purpose of promotional materials, news releases, or other published formats for either the local Girl Scout Councils or Girl Scouts of the USA. I hereby release and hold harmless Girl Scouts of Kansas Heartland and Girl Scouts of the USA from any claim arising from the use of these images. **INITIAL HERE:** _____

This Health History and Authorization Form is complete and accurate. The participant has permission to engage in all prescribed activities, except as noted.

Signature of Participant or Parent/Guardian of Minor Participant: _____

Date: _____

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Health History and Authorization Form plus Medical Exam

Section C: (*medical examination*) *is to be* completed for Girl Scout activities lasting three or more nights and high-risk activities (i.e. rappelling, white-water rafting, etc). The examination must by completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months, or sooner if a health issue is present.

Attach Section C – Medical Exam to Sections A and B – Health History and Authorization Form.

Participant's Name: _____ **Date:** _____

This section is to be completed by a physician after the review of the participant's Health History and Authorization Form

Section C) Medical Exam:

Height: _____ Weight: _____ B. P.: _____/_____ Hearing: R ___ L ___

Eyes: With Glasses R 20/____ L 20/____ Without Glasses R 20/_____ L 20/_____

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

_____ Nose	_____ Abdomen	_____ Urinalysis*	Other: _____
_____ Throat	_____ Hernia	_____ HGB*	_____
_____ Teeth	_____ Genitalia	_____ Appearance/Nutrition	_____
_____ Heart	_____ Skin	_____ General Physical State	_____
_____ Lungs	_____ Musculoskeletal	_____ General Emotional State	_____

*Girls should have this test if she had not had it since entering puberty.

Record of Immunization: *Must be completed in detail.*

	Date Series was Completed	Year of Last Booster
Hep B	_____	_____
DTap/Tdap	_____	_____
DT/Td	_____	_____
Hib	_____	_____
IPV/OPV	_____	_____
PCV7	_____	_____
MMR	_____	_____
Varicella	_____	_____
Other:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

	Date Series was Completed	Year of Last Booster
Typhoid	_____	_____
Paratyphoid	_____	_____
Cholera	_____	_____
Yellow Fever	_____	_____
Typhus	_____	_____
Rocky Mountain Spotted Fever	_____	_____
Tuberculin Test: Year last given		_____ Result _____
Not required immunizations, but recommended		
HPV	_____	_____
Rota	_____	_____
MCV4/MPSV4	_____	_____
Hep A	_____	_____
TIV/LAIV	_____	_____

Personal and religious beliefs dictate against immunizations: Yes No

Physician Information

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

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

Signature of Licensed Physician: _____ **State License Number:** _____ **Date:** _____