girl scouts of kansas heartland

Girl Scouts of Kansas Heartland
Health History and Authorization Form

Section A and B: (personal information, health history, authorization) 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. The Health History and Authorization Form must be reviewed annually. When changes are necessary, complete a new form.

☐ **Minor** ☐ **Adult**

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

*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

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.	
4.	

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 her 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.			
4.			
5.			

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:

_____

_____

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:** _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Health History and Authorization Form** is for health care concerns at Girl Scout activities. All records will be handled by troop volunteers or program staff whose job includes processing or using this information for the benefit of the participant. Necessary information may be shared with additional volunteers or program staff in order to provide adequate participant safety and health care during Girl Scout activities. This form may be retained by Council according to Kansas state law; access to the information will be limited, but copies may be requested from the event sponsor, by the participant, or their legal representatives. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. **INITIAL HERE:** _____

MEDIA PERMISSION:

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 purposed 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 Girl Scout activities, except as noted.

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

Date: _____