girl scouts of the chesapeake bay

# GSCB Girl Health Form

**To be completed by a parent or legal guardian.**

Please complete and return this form to your Troop Leader and/or event lead. If you have any questions, please reach out to MemberCare@cbgsc.org or call 1-800-341-4007.

| | | |
|---|---|---|
| Girl Name (first, middle, last): | DOB: | Age: |
| Street Address: | State: | City/Zip: |

| | | |
|---|---|---|
| Name of Parent/Guardian: | Home Address: | Phone: |
| Employer: | Business Address: | Work Phone: |
| Name of Parent/Guardian: | Home Address: | Phone: |
| Employer: | Business Address: | Work Phone: |

Person other than parent/guardian to be notified in emergency situation when parent/guardian is not available:

1.

2.

Emergency Medical Care

I, , the parent (or legal guardian) of _____ , who is my minor child, hereby authorize emergency medical treatment for my child in the event I cannot be contacted to give permission to treat. I understand I will be financially responsible for the cost of such treatment.

_____ (sign) _____ (date)

Transportation

I, , the parent (or legal guardian) of _____ , who is my minor child, hereby give permission for my child to be transported with her caregiver.

_____ (sign) _____ (date)

| Name of Girl's Physician: | | Phone: | Office Hours: |
|---|---|---|---|
| Physician Address: | This girl is covered by family/hospital insurance:<br>Yes ☐ No ☐ | Insurance Company: | |
| Policy Number: | Subscriber: | | Insurance Company Phone Number: |

**Medication:** "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please review travel instructions about required packaging/ containers. Many countries require original pharmacy containers with labels showing the girl's name and how the medication should be given. Provide enough of each medication to last the entire time the girl will be traveling.

| **Name of Medication** | **Date Started** | **Reason for taking it** | **When is it given** | **Amount or dose given** | **How is it given** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

The following non-prescription medications may be carried by an adult chaperone and are used on an as needed basis to manage illness and injury. () are suggested brand names, but may be substituted with other brands. Mark those the girl should **NOT** be given:

- ☐ Acetaminophen (Tylenol)
- ☐ Phenylephrine decongestant (Sudafed PE)
- ☐ Antihistamine/allergy medicine
- ☐ Diphenhydramine antihistamine/allergy medicine (Benadryl)
- ☐ Sore throat spray
- ☐ Lice shampoo or cream (Nix or Elimite)
- ☐ Calamine lotion
- ☐ Laxatives for constipation (Ex-Lax)
- ☐ Ibuprofen (Advil; Motrin)
- ☐ Pseudoephedrine decongestant (Sudafed)
- ☐ Guaifenesin cough syrup (Robitussin)
- ☐ Dextromethorphan cough syrup (Robitussin DM)
- ☐ Generic cough drops
- ☐ Antibiotic cream
- ☐ Aloe
- ☐ Bismuth subsalicylate for diarrhea (Kaopectate; Pepto-Bismol)

The information provided is accurate: _____ (sign and date)

**Healthcare Providers:**

| | |
|---|---|
| Name of Girl's Primary Doctor(s): | Phone: |
| Name of Dentist(s): | Phone: |
| Name of Orthodontist(s): | Phone: |

**What have we forgotten to ask?** Please provide in the space below any information about the girl's health that you think important or may affect the girl's ability to participate in the planned travel. Attach additional information, if needed.