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 the Girl Program Department. The form may be emailed to program@cbgsc.org, faxed to (302) 456-7188, or mailed to GSCB, Girl Program Department, 225 Old Baltimore Pike, Newark, DE 19702.

**Due to council: 6 weeks in advance of travel.**

| | | |
|---|---|---|
| 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: Yes ☐ No ☐ | Insurance Company: | |
| Policy Number: | Subscriber: | | Insurance Company Phone Number: |

**Immunization History:** Please provide a complete and current immunization record for your child from her physician.

If your Girl Scout has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Parent/Guardian: _____ Date: _____

**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)

**General Health History:**
Has the girl:

| | | | |
|---|---|---|---|
| 1. Ever been hospitalized? | | 11. Had fainting or dizziness? | |
| 2. Ever had surgery? | | 12. Passed out/had chest pain during excercise? | |
| 3. Have reoccurring/chronic illnesses? | | 13. Had mononucleosis (mono) during the past 12 months? | |
| 4. Had a recent infectious disease? | | 14. Had problems with periods/ menstruation? | |
| 5. Had a recent injury? | | 15. Had problems falling asleep/ sleepwalking? | |
| 6. Had asthma/wheezing/shortness of breath? | | 16. Ever had back/joint problems? | |
| 7. Have diabetes? | | 17. Has any known allergies? | |
| 8. Have seizures? | | 18. Have problems with diarrhea/ constipation? | |
| 9. Had headaches? | | 19. Have any skin problems? | |
| 10. Wear glasses, contacts, or protective eyewear? | | 20. Traveled outside the country in the past 9 months? | |

Please explain **"YES"** answers in the space below noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional and Social Health:** Write "YES" or "NO" for each statement.
Has the girl:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? _____
2. Ever been treated for emotional or behavioral difficulties or eating disorder? _____
3. During the past 12 months, seen a professional to address mental/emotional health concerns? _____
4. Had a significant life event that continues to affect the girl's life? (ex. history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster.) _____

Please explain "YES" answers in the space below, noting the number of the questions. The lead adult chaperone may contact you for additional information.

**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.

# Authorization for Medical Treatment for Minors

If your Girl Scout needs medical or dental attention, you, as a parent/guardian, must give permission. For those times when it will be hard to contact you, you can give permission to other adults. They can then act for you in permitting medical or dental care for your child when you are not available. This is a legal document. With it, you may appoint other adults to act for you. This document will be kept with the responsible adult.

All parents/guardians must sign the authorization form, which MUST be notarized. If the parents are not together, parent consent from both parents is still necessary. If one parent is the custodial parent or deceased, there MUST be legal proof/documentation of this status.

I/We,_____ and _____ being the parent(s) or legal guardian(s) of the named minor,_____ , do hereby appoint:

| Name(s): | Address: | Phone: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**To act in my/our behalf in authorizing unexpected medical, dental, surgical care or hospitalization for the above named minor during the period of my/our absence from:**_____ (date of travel). *This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unex-pected medical, dental, surgical care or hospitalization may be required. I give permission to the physician selected by the responsible chaperones to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need-to-know" basis with traveling adult chaperones and council staff. I give permission to photocopy this form. In addition, the responsible chaperones have permission to obtain a copy of my child's health record from providers who treat my child, and these providers may talk with adult chaperones and council staff about my child's health status.*

Signature of mother or guardian: _____

Printed name of mother or guardian: _____

Signature of father or guardian: _____

Printed name of father or guardian: _____

In the state of and county of on this day of , before me personally appeared and to me known to be the individual, or individuals, described in and who executed the within and foregoing instrument and acknowledged that he/she/they signed the same as his/her/their free and voluntary act and deed, for the uses and purposes therein mentioned.

Given under my hand and official seal this day of (month), (year).

Notary Signature: _____

Notary Printed Name: _____

Notary Public in and for the State of .

My appointment expires on _____.