GSCB International Travel Health History Form

This form is required to be completed for Girl Scouts and Adult participants for international travel. The Troop leader must retain a copy of the GSCB International Travel Health History Form for each troop member and keep ALL information CONFIDENTIAL. PARTICIPANTS WILL NOT BE ABLE TO ATTEND WITHOUT THIS COMPLETED FORM. Adults completing this form may sign for themselves on the Parent/Guardian signature line. This form will need to be notarized.

I am filling this form out for: ☐ Girl Scout ☐ Adult Member

Contact Information:

Last Name	First Name	Middle Name	D.O.B	Age
Street Address		City/State	Zip Code	
Custodial Parent/Guardian	Day/Work Phone	Evening/Home Phone	Cell/ Mobile Phone	
2nd Parent/Guardian	Day/Work Phone	Evening/Home Phone	Cell/ Mobile Phone	

If an emergency arises, and a parent/guardian cannot be reached, please contact the following people: (Adult Participants please list emergency contacts here)

Emergency Contact #1 Name		Phone Number	Relationship
Emergency Contact #2 Name		Phone Number	Relationship

Health Information:

Every participant traveling internationally should visit their own doctor to discuss their travel health requirements and any vaccinations.

Name of Physician	Clinic Name	Phone
Insurance Carrier	Policy/ Group #	
Name of Primary Insured	Primary Insured DOB	

Answer Yes or No for the following for the participant:

Ever been hospitalized?		Had fainting or dizziness?	
Ever had surgery?		Passed out/had chest pain during exercise?	
Have reoccurring/ Chronic illness?		Had mononucleosis during the past 12 months?	
Had a recent infectious disease?		Had bleeding/clotting disorders?	
Had a recent injury?		Ever had back/joint problems?	
Had asthma/wheezing/shortness of breath?		Has any known allergies?	
Have diabetes?		Have problems with diarrhea/constipation?	
Have seizures?		Have any skin problems?	
Had Headaches/migraines?		Have problems falling asleep/sleepwalking?	
Wear glasses, contacts, or protective eyewear?		Has traveled outside the country in the past 9 months?	
Hypertension/ high blood pressure?		Menstrual cramps?	
Nose bleeds?		Speech or hearing impairment?	

Please answer the following questions completely:

Does the participant have any health concerns we should be aware of? If so, please provide any important information, such as symptoms to watch for or care needs.
Does the participant have any specific dietary needs or restrictions? If so please describe.
Does the participant have any emotional, psychological, or behavioral health concerns we should be aware of?

Allergies

Does the participant have any allergies? If, so please explain the cause, reaction, and how it should be handled. If they need an EpiPen, Inhaler, or Insulin please indicate if they can self-administer.

Health Information Privacy Statement:
This Health History Record may be used solely for the benefit of the participant to provide adequate participant safety and healthcare. Access to this information will be limited. The Troop Leader shall retain this form for their records for one year. After one year, the Troop leader shall destroy this form.

Medical Release and Waiver
Please initial next to each statement:

	The above health history and medication details/instructions are accurate and complete to the best of my knowledge.
	I authorize for GSCB staff or volunteers to administer and store the provided medications per the provided dosage information and special instructions provided above.
	This form may be printed/photocopied.
	If any of the information provided changes I will notify Troop Leader immediately.
	I give permission to medical personnel to provide necessary healthcare; to administer medications; to order X-rays, tests, and treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation.
	If parent/guardian or emergency contact cannot be reached in an emergency, I hereby give permission to the physician to secure and administer treatment, including hospitalization, and to order injections and/or anesthesia and/or surgery for the participant named above.
	I give permission for GSCB staff or volunteers to release this information to emergency responders, hospital personnel, pharmacy staff, ect. I understand that every effort will be made to contact the parent/guardian/ emergency contact prior to admission.

In witness where of, this release and waiver has been carefully read and contents of this document are understood by the undersigned. This release and waiver shall be effective for one year following the completion of the Health History Record completion date. I hereby waive and release the Girl Scouts of the Chesapeake Bay and all individuals, staff members, or volunteers working in connection with Girl Scouts activities from any possible claims for injury or property which might arise from the connection with me or my child's participation. I do not hold the Council responsible for any accident or illness which might occur. The undersigned freely execute this release and waiver on the date shown below.

Parent/Guardian or Adult Participant Name: _____ Date (mm/dd/yyy)_____

Parent/Guardian or Adult Participant Signature: _____ Date (mm/dd/yyy)_____

Notarized Authorization for Medical Treatment

If the participant needs medical or dental attention, permission must be given for someone else to act for you in permitting medical or dental care. This is a legal document. With it you may appoint any other participating GSCB staff or volunteer adult to act for you or on your behalf. If you are filling this form out for a minor, **all legal guardians** must sign the authorization form. If a single parent or guardian has custody, attach documentation stating that the minor is in the sole custody of the signer of the forms. You must sign the authorization form and it **must be notarized**.

I/We,_____ and _____, do hereby appoint:

Names	Address	Phone

To act on my behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above-named adult or minor participant during the period from: _____ (dates of travel). This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required. I give permission to the physician to order x-rays, routine tests, and treatment related to me or my child's health for both routine healthcare and in emergency situations. If parent/guardian or emergency contact 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 me or my child. I understand the information in this form will be shared on a "need to know" basis with appointed adults and or GSCB staff. I give permission to photocopy this form and to obtain a copy of me or my child's health record from providers, these providers may also talk to appointed adults and or GSCB staff about me or my child's health status.

For adult participants:

Signature of Adult participant: _____ Printed name of Adult participant: _____

For Minors:

Signature of mother/guardian: _____ Printed name of mother/guardian:_____

Signature of father/guardian: _____ Printed name of father/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 _____