

HEALTH HISTORY AND EXAM RECORD FOR MINOR STAFF



GIRL SCOUTS HEART OF CENTRAL CALIFORNIA 3005 GOLD CANAL DRIVE RANCHO CORDOVA, CA 95670

Name _____ Birthdate _____ Troop # _____
Address _____ City _____ Zip _____ Home phone (____) _____
Family medical/hospital insurance carrier _____ Policy or Group No. _____

Parent/Guardian _____ **Parent/Guardian** _____
Day Phone (____) _____ Day Phone (____) _____
Evening Phone (____) _____ Evening Phone (____) _____

Emergency Contacts (in the event parents cannot be reached)

Name _____	Name _____
Relationship _____	Relationship _____
Day Phone (____) _____	Day Phone (____) _____
Evening Phone (____) _____	Evening Phone (____) _____
Cell Phone (____) _____	Cell Phone (____) _____
Email _____	Email _____

The child may **NOT** be released to the following individuals:

Name _____	Name _____
Relationship _____	Relationship _____
Phone (____) _____	Phone (____) _____

Does the participant have any allergies, special needs or a special diet we should be aware of? Yes No

If Yes, please explain: _____

(For example, please list all medications, plants, animals, etc. that the participant is allergic to and/or indicate whether the participant has special needs like asthma or diabetes.)

Please provide any information in relation to the care of the participant that would be useful to the adult in charge. Also indicate any activities to be encouraged or restricted. _____

Any know recent illness or exposure to contagious disease (within the last six weeks)? Yes No

If Yes, please explain: _____

The above information is correct to the best of my knowledge, and my daughter has my permission to engage in all activities, except as noted. **I hereby authorize Girl Scouts Heart of Central California, through the adult person(s) caring for my daughter, to order emergency X-rays, anesthetic, medical or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician. It is understood that every reasonable effort will be made to contact me or the person noted above before taking this action. I understand that this permission is given in advance of need for any diagnosis, treatment, or hospitalization.**

Date Signature of parent or legal guardian

