GIRL/ADULT HEALTH HISTORY

For (girl/adult name):	Date of birth:	Present age:	
Address:	City:	State:	Zip:
Mother's/guardian's name:			
Day phone number: - -	Evening phone number: - -		
Father's/guardian's name:			
Day phone number: - -	Evening phone number: - -		
If parent/guardian cannot be reached in case of an emergency, please call (name):			
Day phone number: - -	Evening phone number: - -		
Relationship to participant:			
Name of physician:	Phone number: - -		
Name of dentist/orthodontist:	Phone number: - -		
Date of last health exam:	Were any complicating medical problems noted in exam? ☐Yes ☐No		
If yes, please explain:			
Is the participant currently under the care of a physician or psychologist? ☐Yes ☐No			
If yes, for what?			
Is the participant currently taking medication on a regular basis? ☐Yes ☐No			
If yes, what and for what?			

Anyone who has a known complicating medical problem or who has had a serious illness or injury or an operation since the last health examination must submit a written statement from a physician giving permission to participate in any activity that normally requires an annual health history or health exam.

HEALTH HISTORY (Please check and include dates where appropriate.)
This information is mandatory for children and adults.

Chronic or Recurring Illnesses (check those that apply):		**Other Health Conditions** (check those that apply):	
☐Asthma	☐Musculoskeletal disorders	☐ADHD	☐Motion sickness
☐Bleeding/clotting disorders	☐Seizures	☐Bedwetting/Sleep disturbances	☐Nosebleeds
☐Diabetes	☐Other (specify):	☐Constipation	☐Sickle cell trait or disease
☐Ear infection		☐Emotional disturbances	☐Special dietary regimen
☐Heart defect/disease		☐Fainting	☐Wears glasses/contact lenses
☐Hypertension		☐Hearing impairment	☐Other (specify):
☐Kidney disease		☐Menstrual cramps	
Allergies (check those that apply and specify nature of allergic reaction):			
☐Animals:		☐Medicines/drugs:	
☐Food:		☐Plants:	
☐Hay fever:		☐Pollen:	
☐Insect stings:		☐Other (specify):	

☐If Medical Exemption is requested (i.e., due to decision not to vaccinate), please skip to page 2 *Girl Scout Medical Exemption Application.*

INOCULATION RECORD This information is mandatory for children only.
Please complete the table below with dates or attach a Physician Record, unless a Medical Exemption Application is being filed.

Immunization History	Years Primary Series Complete	Year of Last Booster
D.T.P./DTaP		
Td		
MMR (measles/mumps/rubella		
Chicken pox vaccine (varicella)		
Polio vaccine		
Hib		
Hepatitis B		
Tuberculin test (most recent)		

Are there any physical conditions for which special arrangements need to be made? ☐Yes ☐No
If so, what?
Additional information needed by adult leader about this participant:

_____ is physically fit and able to participate in the Girl Scout programs, including summer camp and trips of not more than two nights. I give permission to the physician to order x-rays, routine tests, and treatment for the health of my child in the event that I cannot be reached in an emergency. To the best of my knowledge, the above information is complete and accurate. I agree that videotapes, photographs, and motion picture film in which I/she appear, and/or audio recordings made of my/her voice may be used by Girl Scouts of Virginia Skyline Council and Girl Scouts of the USA, their assigns or successors, in whatever way they desire. Furthermore, I hereby consent that such photographs, films, recordings, and the plates and/or tapes from which they are made shall be their property, and they shall have the right to sell, duplicate, reproduce, and make other uses of such photographs, films, recordings, plates, and tapes as they may desire free and clear of any claim whatever on my part.

Name of Girl: _____ may be given acetaminophen (such as Tylenol). ☐Yes ☐No

Signature of parent/guardian or adult participant: _____ Date: _____

IMPORTANT: SIGNATURE REQUIRED!

Girl Scouts of Virginia Skyline Council, Inc.

GIRL SCOUT MEDICAL EXEMPTION APPLICATION

(complete only if medical exemption is being requested (i.e. due to decision not to vaccinate)

_____

(Name of Girl Scout)

I do hereby certify that I am the parent/legal guardian of the Girl Scout named above (the "Girl Scout"). The Girl Scout is presently a minor. I hereby certify and acknowledge that said minor is presently under my care, custody, and control.

It is respectfully requested that the Girl Scout be exempted from all pre-activity physical examination, vaccination and/or immunization requirements in connection with Girl Scout activities. To the best of my knowledge and belief, she is and has been in normal good health and is free from all communicable diseases.

In consideration of these exemptions, it is understood that I accept complete responsibility for the health of this minor. I understand the risks associated with failing to receive such physical examinations, immunizations and/or vaccinations, but nevertheless request that the Girl Scout be exempted from these requirements.

It is further understood that should an emergency arise, I will be notified immediately. If I cannot be reached, I direct that the alternate emergency contact be notified.

Notwithstanding anything to the contrary herein, in the event of an emergency, the Girl Scouts of Virginia Skyline Council, Inc., its employees, agents and representatives and any third parties providing emergency medical services (including, but not limited to, emergency medical response personnel, doctors and hospitals, as applicable), are hereby authorized and directed to take such temporary measures as they deem to be reasonably necessary and appropriate to provide appropriate medical care and treatment to the Girl Scout.

Signature of Parent or Guardian

Street:

City:

State: Zip:

Day Phone: ( ) -

Evening Phone: ( ) -

Email: