

HEALTH INFORMATION AND RELEASE FORM

To be completed and reviewed annually by parent/caregiver. This form is to be kept with the troop/group records and accompany the troop/group leader on all troop/group activities. It is designed to provide the troop/group leader with the information needed to access medical care for your girl. It should be reviewed and updated (as needed) when information changes.

COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact. As with any social activity, participation in Girl Scouts could present the risk of contracting COVID-19. While GSGLA takes every safety and preventative precaution, GSGLA can in no way warrant that COVID-19 infection will not occur through participation in GSGLA programs

Name: _____ Date of Birth: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip: _____ Troop/Group #: _____

PART I: PARENT/CAREGIVER INFORMATION AND RELEASE

The above Girl Scout is under the custodial care of:

_____ Both Parents _____ Mother only _____ Father only _____ Caregiver(s) (specify) _____

Mother/Caregiver Name: _____

Address (if different than girl): _____

Phone (day): _____ Phone (evening): _____

Cell Phone: _____ Email: _____

Father/Caregiver Name: _____

Address (if different than girl): _____

Phone (day): _____ Phone (evening): _____

Cell Phone: _____ Email: _____

PART II: EMERGENCY CONTACT AND RELEASE INFORMATION

In the event that I cannot be reached in an emergency, the following are authorized to act in my behalf:

Name: _____ Relationship to Girl: _____

Cell Phone: _____ Other Phone: _____

Name: _____ Relationship to Girl: _____

Cell Phone: _____ Other Phone: _____

PART III: HEALTH CARE INFORMATION:

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Is the girl covered by family medical/hospital insurance? Yes No

If so, carrier or plan name: _____ Policy or Group #: _____

Name of insured: _____ Relationship to girl: _____

MEDICAL HISTORY (check those that apply)

<input type="checkbox"/> Asthma Provoked by: _____ <input type="checkbox"/> Has Prescribed Inhaler	<input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fainting <input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Medical Tags/Devices	<input type="checkbox"/> Nosebleeds <input type="checkbox"/> Seizures <input type="checkbox"/> Skin Condition	<input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Vision Impairment <input type="checkbox"/> Wears Contact Lenses
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Additional health information including **disabilities and/or special needs** (medical, physical, emotional, etc...) Please Specify:

IMMUNIZATION HISTORY (check those that apply)

<input type="checkbox"/> Tetanus (within past 10 years) Date: _____	<input type="checkbox"/> Immunization Records Are Up-To-Date <input type="checkbox"/> N/A
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ALLERGY HISTORY (check those that apply)

<input type="checkbox"/> Animals <input type="checkbox"/> Chlorine (pool)	<input type="checkbox"/> Hay Fever <input type="checkbox"/> Other _____	<input type="checkbox"/> Insect Stings _____	<input type="checkbox"/> Plants/Pollen _____	<input type="checkbox"/> Medicine/Drugs _____
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FOOD: Please list all that we should be aware of.

Indicate if **Intolerant (I)** or **Allergic (A)**. Ex. Strawberries **A** , Milk **I**

<input type="checkbox"/> Corn _____	<input type="checkbox"/> Gluten/Wheat _____	Other Food Allergies Aware Of: <input type="checkbox"/> Fruits/Veggies _____ _____ _____
<input type="checkbox"/> Dairy _____	<input type="checkbox"/> Peanuts _____	
<input type="checkbox"/> Eggs _____	<input type="checkbox"/> Shellfish _____	
<input type="checkbox"/> Fish _____	<input type="checkbox"/> Soy _____	
<input type="checkbox"/> Food Coloring _____	<input type="checkbox"/> Tree nuts _____	

Inhaler or Epinephrine Used (will add to Medicine form)

Dietary special needs _____

If any allergy box was checked, please indicate what the reaction is. Such as: strawberries/rash, milk/cramps, etc.

PART IV: MEDICATION (For day outings or overnights only.)

Over-the-counter medication, such as sunscreen, insect repellent, pain relievers, antibiotic ointment, antiseptic wipes, etc. cannot be administered by Girl Scout Leaders unless the Over-the-Counter (OTC) Form is completed and signed by a parent/caregiver. Also, if a Girl Scout is required to carry or regularly receive prescription or over-the-counter medications (including Epi-Pens and Inhalers) that will be provided by a parent/caregiver, that must be noted on the Provided Prescription and/or Provided OTC Medication Form as well.

Permission Granted (see attached OTC/Rx Permission Form)

Permission Not Granted (no form attached)

PART V: EMERGENCY MEDICAL AUTHORIZATION: In the event of an emergency, every effort will be made to contact a parent/caregiver or emergency contact. I hereby give authorization to Girl Scouts of Greater Los Angeles to seek treatment for my child and/or dependent minor by a licensed physician pursuant to California Family Code Section 6910 and California Civil Code Section 25.8. I know of no reason(s) why my girl may not participate in prescribed activities except as noted on this Health History Form. If permission for emergency medical treatment is not given, I will prepare a signed statement providing the reason, a release of liability, and alternate instructions and attach to this form.

Signature of Parent/Caregiver: _____ Date: _____

Signature of Parent/Caregiver: _____ Date: _____

I do not consent to the care or treatment set forth herein. Describe in detail what is/is not allowed/permitted: