girl scouts
greater los angeles

20__- 20__

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

IMMUNIZATION HISTORY (check those that apply)	
❑ Tetanus (within past 10 years) Date: ____________	❑ Immunization Records Are Up-To-Date ❑ N/A

ALLERGY HISTORY (check those that apply)				
❑ Animals ❑ Chlorine (pool)	❑ Hay Fever ❑ Other ________	❑ Insect Stings ____________	❑ Plants/Pollen ____________	❑ Medicine/Drugs ____________
FOOD: Please list all that we should be aware of. Indicate if **Intolerant (I) or Allergic (A).** Ex. Strawberries **A** , Milk **I**				
❑ Corn ________ ❑ Dairy ________ ❑ Eggs ________ ❑ Fish ________ ❑ Food Coloring ________	❑ Gluten/Wheat ________ ❑ Peanuts ________ ❑ Shellfish ________ ❑ Soy ________ ❑ Tree nuts ________	Other Food Allergies Aware Of: ❑ Fruits/Veggies ____________		
❑ 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:**

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