girl scouts of western washington

Health History for Youth and Adult Girl Scout Participants

☐ Youth Participant ☐ Adult Participant

Full Name:	Birth Date ____/___/_____
Primary Phone:	Alt. Phone
Address:	
City:	State & Zip
IN CASE OF EMERGENCY, NOTIFY:	
Full Name:	Relationship
Primary Phone:	Alt. Phone
Address:	
City	State & Zip
SECONDARY EMERGENCY CONTACT:	
Full Name:	Relationship
Primary Phone:	Alt. Phone
Address:	
City	State & Zip

Do you have any health or medical issues that should be communicated in case of an emergency? (i.e. severe allergies, EpiPen, diabetes, dietary restrictions, severe asthma, etc.)

☐ Yes ☐ No If yes, please explain:

HEALTH CONDITIONS			
Condition	Symptoms	Treatment	Date of Last Occurrence

Do you have any restrictions concerning physical activities?

☐ Yes ☐ No If yes, please explain:

Is there a specific dietary regiment to follow (ex. vegan, gluten free, halal, diabetic, dairy, etc.)?

☐ Yes ☐ No If yes, please explain:

INSURANCE INFORMATION

Carrier Name	ID #	Group #
Member Services Phone:		
Address:		

PHYSICAN INFORMATION

Primary Care Physician Name:	
Primary Care Physician Phone:	

In case of emergency, Girl Scouts of Western Washington will provide or engage appropriate emergency medical or surgical treatment, and/or hospitalization if necessary. It is understood that every effort will be made to reach the emergency contacts named above.

IMMUNIZATION POLICY

To view the current council specific Immunization policy visit Volunteer Policies.

RECORD OF IMMUNIZATION

Date of last Tetanus vaccine: ___/___/____

Select one of the following:

☐ I attest that the attendee's immunizations, as required for school, are up to date.

☐ Attendee has not received immunizations. Note: Please contact customercare@girlscoutsww.org to obtain and complete an immunization waiver. The waiver is required for participation.

MEDICATIONS

A qualified Health Care Professional (RN, LPN, DMD, or MD) or a PA Medication Administration certified approved volunteer may administer medications to participants. Arrangements between parents/caregivers and GSWW Approved Volunteer for all medications dispensed must include:

1. Prescription and over-the-counter medications must be provided in their original container.

2. Prescription medications must contain the physician prescribed orders, including instructions.

3. Both prescription and over-the-counter medications must be given to the Approved Volunteer or First Aider/Health Care Professional.

4. Some Life-threatening conditions will require medications to be carried and secured by the participant, youth or adult, and are approved for carrying in first aid kits. These include Epi-pens needed for insect stings or serious food allergies, asthma inhalers, and items needed for diabetic and seizure emergencies.

PRESCRIPTION MEDICATION

In the space below, please list any prescription medication that participant is required to take, including any self-administered emergency medication such as an Epinephrine injector or rescue inhaler.

Medication	Purpose	Self-Administer?	Dosage
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

		☐ Yes ☐ No	
		☐ Yes ☐ No	

☐ **Permission to Self-Administer Medication**: I confirm that my Girl Scout has the knowledge and skills to safely have readily available (carry or possess outside of the regular supervision of the troop leader/first aider) and self-administer the indicated emergency medication as medically necessary at Girl Scout activities. The troop leader/first aider will be notified if they must use their medication.

OVER-THE-COUNTER MEDICATION:

In the list below, please select any over-the-counter medication that the participant is **NOT** permitted to take.

☐ Ibuprofen	☐ Calamine Lotion	☐ Liquid Tears	☐ Anti-fungal Cream
☐ Aloe Vera	☐ Cough Drops	☐ Menstrual Cramp Relief	☐ Antacid
☐ Bacitracin (i.e. Neosporin)	☐ Dramamine	☐ Expectorant	☐ Acetaminophen
☐ Antihistamine	☐ Anti-diarrheal	☐ Decongestant	☐ Other_____

SIGNATURES

TERMS & CONDITIONS This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all activities, except as noted by me and/or examining physician. I am the parent or guardian having legal custody of the youth named above. I authorize all medical, surgical, diagnostic, and hospital care or procedures which may be performed or prescribed for the participant by a licensed physician or hospital, when efforts to contact emergency contacts and when deemed immediately necessary or advisable by the physician to safeguard participant's health. I waive my right of informed consent to such treatment. I will take full responsibility for all charges that occur. Girl Scout insurance is secondary to your primary insurance. I understand the information on this form will be shared on a 'need to know' basis with staff. I give permission to photocopy this form. In addition, GSWW has permission to obtain a copy of the participant's health record from providers who treat the participant, and these providers may talk with the staff about the participant's health status. By my signature I affirm that this health history is correct and complete to the best of my knowledge and that I have read, understood, and agree to the Terms and Conditions specified in this form.

Parent/Guardian Signature: _____ Date: _____/____ /_____

Adult Participant Signature: _____ Date: _____/____ /_____