girl scouts of tropical florida

GIRL SCOUT COUNCIL OF TROPICAL FLORIDA, INC.
(Serving Dade and Monroe Counties)

HEALTH HISTORY AND PARENT RELEASE FOR MEDICATION

Please complete and sign *both* sides of this form.

PLEASE COMPLETE USING BLACK INK ONLY.

Name of Child_____

Name of Parent or Guardian_____

Address_____Zip_____

Home Phone #_____Work #_____ Email:_____

Additional Emergency Contact_____

Phone #_____

Please check the appropriate box:

☐ My child may **not** receive any medication. I understand that I will be contacted immediately if my child experiences any physical discomfort.

☐ I hereby give permission for my child to receive the medications below if necessary as determined by the health supervisor. We will not give Aspirin or Aspirin containing products.

yes/no	Hydrocortisone ointment 1%	yes/no	Absorbine Jr.
yes/no	Tylenol	yes/no	Tinactin
yes/no	Ibuprophen (Advil, Nuprin)	yes/no	Visine Eye Drops
yes/no	Sunscreen (without PAVA)	yes/no	Murine Eye Drops
yes/no	Kaopectate	yes/no	Betadine Solution
yes/no	Milk of Magnesia	yes/no	Hydrogen Peroxide
yes/no	Ex-Lax	yes/no	Tincture Iodine
yes/no	Benadryl	yes/no	Tincture Methiolate
yes/no	Calamine Lotion (do not combine with Benadryl)	yes/no	Bactine
yes/no	Co-tylenol Liquid	yes/no	Sting Relief (for insect bites)
yes/no	Neosporin Ointment		(Each girl bring her own)
yes/no	Swimmers Ear (drops for prevention)	yes/no	RID (shampoo for head lice)
yes/no	Other_____		

Parent or Guardian Signature_____

I hereby authorize the health supervisor to administer the prescription medication listed below (to be provided by participant).

Name of Medication	Dosage	Administration
1.		
2.		
3.		

Physician's Name_____Phone #_____

Physician's Signature_____

Parent or Guardian Signature_____Date_____

HEALTH HISTORY

This is a health history record to be completed by the parent or guardian. A physician's signature is not required. Check special conditions or diseases your child has encountered.

____ Bedwetting ____ Hearing Problems ____ Asthmatic

____ Diabetic ____ Menstrual Cramps ____ Special Diet

____ Epileptic ____ Nosebleeds ____ Contact Lenses/Glasses

____ Fainting ____ Speech Problems ____ Sleep Walking

____ Chicken Pox ____ Braces/Retainer ____ Measles

____ Mumps

Allergies (specify)_____

Behavior (specify)_____

Other_____

Illnesses and injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness

☐ Ear Infection ☐ Bleeding/Clotting Disorders ☐ Hypertension ☐ Asthma

☐ Heart Defect/Disease ☐ Musculoskeletal Disorders ☐ Seizures ☐ Diabetes ☐ Other_____

Date of last health examination:_____

Were any complicating medical problems noted in last health examination?_____

Is participant currently under the care of a physician or psychologist?_____

Since last health exam, has participant had:

a serious injury requiring medical attention? ____ an illness lasting more than five days? ____

any prescribed or over-the-counter medication ____ a surgical operation or fracture? ____

treatment in a hospital or emergency room? ____ any restrictions concerning physical activities? ____

any exposure to a contagious disease? ____

Please explain any "yes" answers to the above questions. Include dates:

_____

HEALTH CERTIFICATION

This is to certify that _____ is in good physical condition, has had no recent exposures to contagion, and has my permission to participate in the total program. In case of emergency I understand that every effort will be made to contact parents or guardian. In the event I cannot be reached I hereby give my permission to the physician selected by the Event Director to hospitalize and secure proper treatment for my child as named above. For campers in Resident Camp: I certify in addition that my child has not had any operations or serious illness between her health examination for camp and the opening of the camp session.

Signature of Parent or Guardian_____Date_____

PHYSICAL EXAMINATION FORM

National and international travel for more than 3 nights, strenuous activity, contact sports, on an organized competitive basis, summer resident campers and travel campers must have this form completed in the past 24 months by a U.S. licensed physician.

Campers Name:_____

Date of Examination:_____

Codes: ***Satisfactory*** ***4***

Not Satisfactory ***8***

Not Examined ***0***

Height_____Weight_____B.P._____

Appearance - Nutrition_____

Eyes

w/o glasses: R - 20/__ L - 20/__; w/glasses: R - 20/__ L - 20/__

Ears_____

Hearing_____R_____L_____

Nose_____

Throat_____

Teeth_____

Heart_____

Lungs_____

Abdomen_____

Genitalia_____

Hernia_____

Skin_____

Musculoskeletal_____

Urinalysis_____HGB*_____

Other Notes_____

*Not required for every health examination. A Brownie or Junior should have this test if she has not had it, either when entering school or at any time since. A Cadette or Senior should have this test if she has not had it since entering puberty.

IMMUNIZATIONS

Immunization	Year Primary Series Completed	Year of Last Booster
D. T. P.	_____	_____
Diphtheria		_____
Tetanus		_____
Whooping Cough		_____
Oral Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Other	_____	_____

Tuberculin Test Type_____

Year Last Given_____

Result_____

Physician's Comments and recommendations. Give details of management of significant illnesses.

This person is in satisfactory condition and may engage in all usual activities except as noted.

Physician_____

Address_____

City_____State_____Zip_____

Telephone #_____Date_____

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