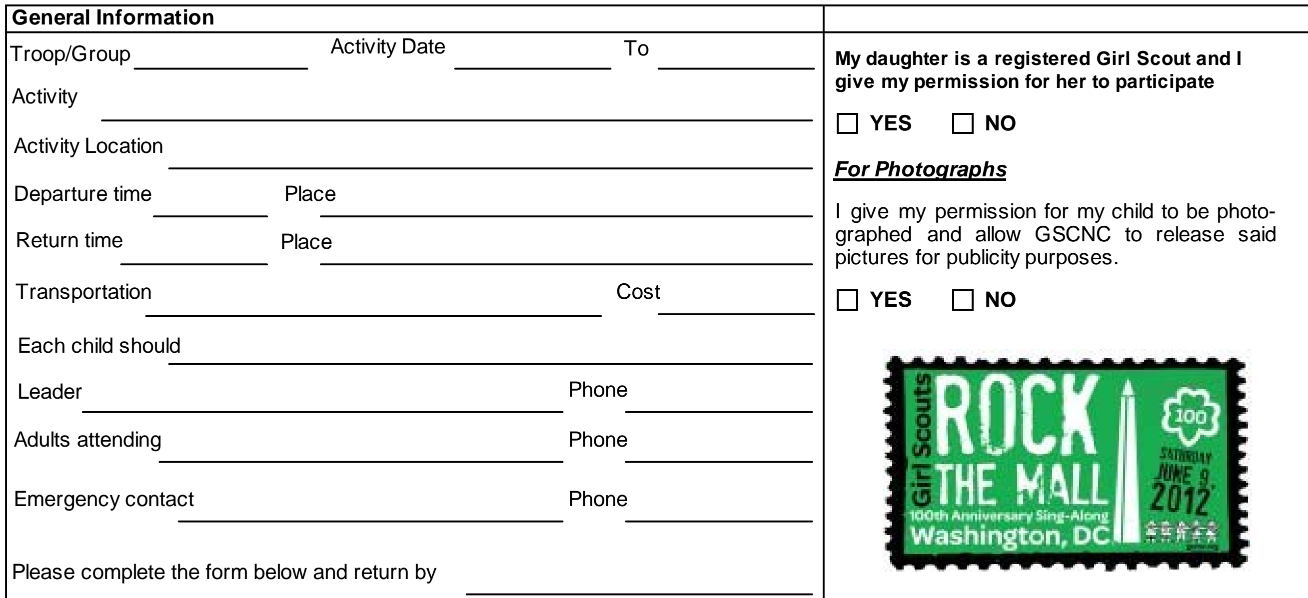
Your Council Name Here:

PARENTAL PERMISSION/HEALTH HISTORY FOR GIRL SCOUTS ROCK THE MALL

Leader please check all that apply:

☐ Day Trip ☐ Overnight ☐ High Adventure ☐ Sensitive Issue



General Information

Troop/Group ______ Activity Date ______ To ______

Activity ______

Activity Location ______

Departure time ______ Place ______

Return time ______ Place ______

Transportation ______ Cost ______

Each child should ______

Leader ______ Phone ______

Adults attending ______ Phone ______

Emergency contact ______ Phone ______

Please complete the form below and return by ______

My daughter is a registered Girl Scout and I give my permission for her to participate

☐ **YES** ☐ **NO**

For Photographs

I give my permission for my child to be photographed and allow GSCNC to release said pictures for publicity purposes.

☐ **YES** ☐ **NO**

General Information

I am the parent/guardian of ______
(Child's Name)

I give special permission and/or instructions for the following medication ______.

This medicine will be properly labeled and given to the adult First Aider.

Mother/guardian ______ Phone ______

Father/guardian ______ Phone ______

Emergency contact ______ Phone ______

Signature ______ Date ______

Use this area to enter any information that would not fit in the above fields or on the following page.

PARENTAL PERMISSION/HEALTH HISTORY FOR GIRL SCOUTS ROCK THE MALL

To be filled out by parent/guardian

Child's Name (first, middle initial, last) ______ Troop # ______ SU# ______ Level ______

Birth Date ______ Age ______ School attending ______ State ______ Grade ______

Home address ______ City ______ State ______ Zip ______

Parent or Guardian ______ Phone: Day ______ Cell ______ Evening ______

Home address ______ City ______ State ______ Zip ______

2nd Parent or Guardian ______ Phone: Day ______ Cell ______ Evening ______

Home address ______ City ______ State ______ Zip ______

Child is in the custodial care of ☐ *both parents* ☐ *mother only* ☐ *father only* ☐ *other* ______

Emergency Contact: *If neither parent/guardian is available in an emergency, contact:*

Name: ______ Relationship ______ Phone: Evening ______ Day ______ Cell ______

Name: ______ Relationship ______ Phone: Evening ______ Day ______ Cell ______

Health History: (*Check all that apply and give approximate dates. Use the Continuation Page as necessary*)

☐ ADD/ADHD ______	☐ Epilepsy ______	☐ Sickle Cell Anemia ______	Wears: ☐ Contacts ☐ Glasses
☐ Arthritis ______	☐ Fainting ______	☐ Sinusitis ______	**Allergies:**
☐ Asthma ______	☐ Hay Fever ______	☐ Skeletal Disease/Disorder ______	☐ Animals ______
☐ Athletes Foot ______	☐ Headaches/Migraines ______	☐ Skin Conditions ______	☐ Bee/Wasp Stings ______
☐ Bed Wetting ______	☐ Hearing ______	☐ Sleep Disturbance/Walking ______	☐ Plants, Ivy/Oak ______
☐ Bleeding/Clotting Disorders ______	☐ Heart Defect/Disease ______	☐ Stomach Upsets ______	______
☐ Bronchitis ______	☐ Hypertension ______	☐ Urinary Tract Infections ______	☐ Drugs ______
☐ Colds/Sore Throats ______	☐ Kidney Disease ______	☐ Chicken Pox ______	______
☐ Constipation ______	☐ Mononucleosis ______	☐ German Measles ______	☐ Foods ______
☐ Convulsions ______	☐ Motion Sickness ______	☐ Measles ______	______
☐ Diabetes ______	☐ Muscle Disease/Disorder ______	☐ Mumps ______	☐ Other ______
☐ Ear Infections ______	☐ Nervous System Disorder ______	☐ Other ______	______

Are there any special needs or accommodations required? If yes, please explain ______

Are there any known behavioral and/or emotional problems? If yes, explain ______

Ever required any psychiatric counseling or hospitalization? If yes, explain ______

Operations or serious injuries ______

Disability or chronic or recurring illness ______

Activities to be encouraged or limited by her physician? ______

Dietary modifications ______

Has this person menstruated? ______ If not, has she been told about it? ______ If so, is her menstrual history normal? ______

Since her last health exam has your child had: ☐ a serious injury requiring medical attention? ______ ☐ an illness lasting longer than one week? ______

☐ an in-patient hospital treatment or the emergency room? ______ ☐ been restricted from participating in any school activities? ______

(Please explain any "YES" answers to the above questions and include dates and/or details. May use the Continuation Page if necessary.)

Immunization History: Are all immunizations up-to-date? ☐ Yes ☐ No If no, please state reason ______

(Give immunization date that the child listed above has had. Complete other information as requested.) DTP or DT (Tetanus) Date: ______

Insurance Information: Company ______ Policy Number ______ Policy Holder ______

Company address: ______ City: ______ State ______

Other: Name of Dentist/Orthodontist: ______ Phone ______

Name of Physician ______ Phone ______ Date of last health exam ______

Preferred Medical Facility: ______ Location: ______

Medication Information: Any prescribed medication being taken? ☐ No ☐ Yes - ☐ Inhaler ☐ Epipen ☐ Other - what, why, when, and dosage?

______

Current Weight ____ Current Height ____ My child may be given (check all that apply): ☐ Aspirin ☐ Benadryl ☐ Ibuprofen ☐ Neosporin ☐ Tylenol ☐ None

IMPORTANT – THIS SECTION MUST BE COMPLETED

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First Aider or Adult in charge to provide routine health care and administer prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by GSUSA, GSCNC or individual units. Should a medical emergency arise during my child's participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied for trips and camping outside of the normal meeting place.

Signature of Parent/Guardian ______ Date ______

*If for religious reasons you cannot sign this form, then submit a legal waiver, which must be signed for attendance/participation.