

## Health History Form - Individual Girl Program

Copy this form for **EACH** program your daughter attends. Forms cannot be transferred from one program to another.

Program: \_\_\_\_\_ Date: \_\_\_\_\_ Name: \_\_\_\_\_  
(Last) (First) (Middle)  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)  
Age: \_\_\_\_\_ Grade: \_\_\_\_\_ B J C S Jul Birth Date: \_\_\_\_\_  
Mother/Guardian Name: \_\_\_\_\_ Daytime Phone # \_\_\_\_\_  
Father/Guardian Name: \_\_\_\_\_ Daytime Phone # \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Daytime Phone # \_\_\_\_\_  
(List an adult that is familiar with your daughter, that is not listed above)  
Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Hospital Affiliation: \_\_\_\_\_ Phone # \_\_\_\_\_  
Health Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_

### Medical Information

**Allergies** Food (please list): \_\_\_\_\_  
Medication (pleases list): \_\_\_\_\_  
Check:  Poison Ivy/Oak  Hayfever  Mosquitoes  Insect Stings (kind) \_\_\_\_\_  
Other: \_\_\_\_\_

**Medications** All medication must be given to the program staff in the original container, clearly marked with the participants's name, date, dosage and times to be given.  
List all current medications, dosage and instructions: \_\_\_\_\_

### Active Health Concerns:

Seizures  Diabetes  Asthma  Fainting  Menstruation  
 Attention Deficit Disorder  Recent Chicken Pox  Other: \_\_\_\_\_  
Behavioral Concerns, Other Conditions: \_\_\_\_\_

Operations or serious injuries (dates): \_\_\_\_\_

Chronic or recurring conditions: \_\_\_\_\_

Specific activities to be restricted: \_\_\_\_\_

Date last seen by physician: \_\_\_\_\_

### Release Statement

In Case of Emergency, I understand every effort will be made to contact parents or guardian of participants. In the event I cannot be reached, I hereby give permission the physician selected by the program director to hospitalize, secure treatment for and to order injections, anesthesia or surgery for my child. This health history is accurate to the best of my knowledge.

This original health history form **must** be retained in our Council records. If you will need a copy of this form, please obtain a copy prior to delivering it to the program your daughter is attending.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Copy this form for each day of program your daughter attends. She will need to bring a completed form to each day of program. Forms can not be transferred from one day of program to another.**