



Parent/Guardian initial if information below is accurate
for ____ 2nd year ____ 3rd year
(no need to fill out new Annual Medical History form until 4th year)

Girl Scouts of Manitou Council – Annual Medical History

A girl's health is primarily the responsibility of her parent(s)/guardian(s). Girl Scouts of the USA recommends annual health examinations, dental checkups, and immunizations against preventable diseases.

Girl Scout's Name _____ Troop # _____ Address/City _____
Parent/Guardian Name _____ Phone _____ Cell Phone _____ Email _____
Family Physician Name _____ Phone _____
Family Dentist/Orthodontist Name _____ Phone _____
Family Medical/Hospital Insurance Carrier _____ Policy # _____ Group # _____
Family Dental Insurance Carrier (if different) _____ Policy # _____ Group # _____
Preferred Hospital Name (include city) _____ Phone _____
Date last medical exam _____ Are immunizations up to date? _____ Date of last tetanus immunization: _____
Current medications (identify medication and explain condition being treated) _____

Please check all that apply:

| Since her last health exam has your daughter had: | Allergies: | Chronic or Recurring Illness: | Other Health Conditions: |
|---|--|---|---|
| <input type="checkbox"/> Serious injury requiring medical attention? <input type="checkbox"/> Treatment in a hospital or emergency room? <input type="checkbox"/> Exposure to a contagious disease other than colds and flu? <input type="checkbox"/> Illness lasting more than 5 days? <input type="checkbox"/> Surgical operation or fracture? <input type="checkbox"/> Physical activity restriction? | <input type="checkbox"/> Animals <input type="checkbox"/> Bee Stings <input type="checkbox"/> Food <input type="checkbox"/> Hay Fever <input type="checkbox"/> Insect Stings <input type="checkbox"/> Medicines/Drugs <input type="checkbox"/> Plants <input type="checkbox"/> Pollen <input type="checkbox"/> Other (Specify) _____ | <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear Infection <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Seizures <input type="checkbox"/> Other (Specify) _____ | <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Constipation <input type="checkbox"/> Emotional Disturbances <input type="checkbox"/> Fainting <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Motion Sickness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Special Dietary Regimen <input type="checkbox"/> Wears Glasses or Contact Lens <input type="checkbox"/> Other (Specify) _____ |

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted. _____

Emergency contact name (other than parent) and relationship to girl _____
Phone _____ Cell Phone _____

This health history is complete and accurate. I know of no reason(s), other than the information on this form, why my daughter should not participate in Girl Scout activities, except as noted. I understand that medication needing to be administered to my daughter during a Girl Scout activity must be given to the adult in charge along with written instructions and permission to administer the scheduled dosage(s). I give my permission to the adult in charge of each Girl Scout activity to act on my behalf in seeking medical treatment for my daughter when necessary.

Signature of parent or guardian _____ Date _____

This Annual Medical History is to be retained by Troop Leader and other adults in charge of Girl Scouts and taken to all Girl Scout troop activities.