

GIRL MEMBER ADULT MEMBER

CONTACT INFORMATION	Troop #: _____ or Individual <input type="checkbox"/>	Service Unit: _____		
	First Name: _____	Middle Name: _____	Last Name: _____	
	Mailing Address: _____		Apt. #: _____	PO Box: _____
	City: _____	State: _____	Zip Code: _____	Phone: () _____
	Cell: () _____	E-mail: _____		
	Parent/Guardian(s) Name and address <i>(If different from girl's): (Complete for girl form only)</i> 1. _____		Phone: () _____ Cell: () _____	
	Parent/Guardian(s) Name and address <i>(If different from girl's): (Complete for girl form only)</i> 2. _____		Phone: () _____ Cell: () _____	
Custodial Care Information: <input type="checkbox"/> Both Parents <input type="checkbox"/> One Parent (specify): _____ <input type="checkbox"/> Other: _____				

HEALTH INFORMATION	Name of Family Physician: _____		Phone: () _____
	Family Medical/Hospital Insurance Carrier: _____		Policy or Group No: _____
	Family Dental Insurance Carrier: _____		Policy or Group No: _____
	Health Information: Age: _____ Date of Birth: _____ <input type="checkbox"/> Immunizations are up to date.		
	Date of last Tetanus shot: _____		
	Date of last health examination: _____		Were there any medical problems at the time? _____
	Does participant have any physical, mental or psychological conditions requiring medication, treatment, or other special restrictions or considerations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state medication and reason: _____		
	Does participant take any prescribed medications or over-the-counter drugs on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state medication and reason: _____		
	Is participant restricted or limited from participating in any physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____		
	Please provide a record of past medical treatment, if any, including injuries or surgeries: _____		
Participant has the following health conditions/allergies/dietary restrictions (food and medications): <input type="checkbox"/> ADHD <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____ <input type="checkbox"/> Allergies (specify): _____			
Emergency Contact (non-parent): _____			
Relationship: _____	Phone: () _____	Cell: () _____	

AUTHORIZATION	PARENT/GUARDIAN AUTHORIZATION This health form is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter/girl should not participate in the prescribed activities except as noted. In the event that my daughter/girl needs medical attention while participating in Girl Scout activities, I authorize the adult in charge to see that my daughter/girl receives routine healthcare, medications, reasonable first aid and to transport my child to a health care facility for emergency services as needed. Signature of parent/guardian: _____ Date: _____
	ADULT MEMBER AUTHORIZATION This health history is complete and accurate. I am able to engage in all prescribed activities except as noted. Signature of adult member: _____ Date: _____

Parent - Please retain a copy for day camp, resident, and other overnight camp programs.

Troop Leader - please retain for your records.