



Girl Scouts®
Where Girls Grow Strong™

Girl Scouts of the Sierra Nevada

605 Washington St. Reno, Nevada 89503
775-322-0642 or 800-222-5406

GIRL HEALTH HISTORY FORM

This health history is to be completed and signed by Parent/Guardian of girl.

First Name		Init		Last Name		Troop No		Service Unit	
Mailing Address						Telephone No ()			
City				State		Zip Code			
Custodial care <input type="checkbox"/> Both parents <input type="checkbox"/> Mother/guardian <input type="checkbox"/> Father/guardian <input type="checkbox"/> Other (specify) _____									
Name of Family Physician					Family Medical/Hospital Insurance Carrier				
Telephone No ()					Policy or Group No				
Mother:					Father:				
Address:					Address:				
Phone - day:		Evening:			Phone-day:		Evening:		
Email:					Email:				
Emergency Contact:					Emergency Contact:				
Phone - day:		Evening:			Phone - day:		Evening:		
ILLNESSES OR INJURIES (Check those that apply)									
<input type="checkbox"/> Ear Infection <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Hypotension <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Seizures <input type="checkbox"/> Other (Specify)									
ALLERGIES (Check those that apply and specify nature of allergic reaction below)					OTHER HEALTH CONDITIONS (Check those that apply)				
<input type="checkbox"/> Animals <input type="checkbox"/> Food <input type="checkbox"/> Pollen <input type="checkbox"/> Insect Stings <input type="checkbox"/> Plants <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Medicines/Drugs _____					<input type="checkbox"/> Bed Wetting <input type="checkbox"/> Constipation <input type="checkbox"/> Menstral Cramps <input type="checkbox"/> Motion sickness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Fainting <input type="checkbox"/> Emotional disturbance <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Sickle Cell Trait or Disease <input type="checkbox"/> Special Dietary regimen <input type="checkbox"/> Wears Glasses or Contact lenses				
Nature of Allergic Reaction: _____ _____									
Current Medications (taken on a regular basis)					IMMUNIZATION HISTORY				
					<input type="checkbox"/> CURRENT <input type="checkbox"/> NOT CURRENT				
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.									
I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted. I give permission for my child to receive emergency medical treatment if needed.									
Signature of Parent/Guardian					Date				