Health History Form

Girl Scouts of Rhode Island, Inc.

1. **Name**_____ Age_____ Birth date_____/___/ Grade_____

Permanent Address_____
(Street) (City/Town) (State) (Zip)

Child is under custodial care of (check one) ☐ Both Parents ☐ Mother only ☐ Father only ☐ Other

Parent/Guardian Name_____ Home Phone(___)_____ Work Phone(___)_____ Cell Phone(___)_____

2. **Emergency Information**

Other than the phones listed above, where can you be reached during the Troop trip?_____

Parents/Guardians, if you cannot be reached in case of an emergency, please list the name of a friend or relative who will be able to help us locate you or who can come and pick up your child.

Name_____ Relationship to Scout_____

Daytime Phone(___)_____ Evening Phone(___)_____ Other Phone(___)_____

3. **Medical Information (Mandatory)**

Health Insurance Company Name_____ Policy #_____ ***OR*** ☐ No Insurance

★Does your child have any allergies and/or dietary restrictions (check one) ☐ Yes ☐ No

If yes, explain_____

★Date of last tetanus shot_____ Are immunizations up-to-date? ☐ Yes ☐ No

★Does your child take any medications? ☐ Yes ☐ No ★Permission to administer according to directions on label. ☐ Yes ☐ No

Special directions_____

★Child carries and may administer an epi-pen or inhaler. ☐ Yes ☐ No

I give my permission to give acetaminophen (Tylenol) ☐ Yes ☐ No and/or Tums for stomach distress ☐ Yes ☐ No as deemed necessary.

Authorization for Treatment: In the event I cannot be reached in an emergency situation, I hereby give permission to the physician selected by the Troop Leader to secure and administer treatment, including hospitalization, for the person named above.

Signature of Parent/Guardian_____ Date_____