GIRL HEALTH HISTORY

PERSONAL INFORMATION:

Girl's Name (Last, First, Middle Initial) ______________________
Birthdate (mm/dd/yy) ______________________ Age ________
Parent's/Gurardian's Name (Last, First, Middle Initial) ______________________
Street Address ______________________
City ______________________ State ________ Zip ________
Home Phone ______________________ Other Phone ______________________

IN CASE OF EMERGENCY NOTIFY:

Name (First and Last) ______________________ Relation ______________________
Address ______________________ Phone ______________________

INSURANCE INFORMATION, PLEASE COMPLETE THE FOLLOWING:

Carrier ______________________ ID Number ______________________ Group Number ________
Member Services Phone ______________________ Address ______________________

HEALTH HISTORY (CHECK THOSE THAT APPLY):

DISEASES	ALLERGIES	CHRONIC OR RECURRING ILLNESS	SUGGESTIONS FROM PARENT
☐ Chicken Pox	☐ Animals ________	☐ Ear Infections	**My daughter has permission to take or use the following, which I have supplied in original containers:**
☐ Measles	☐ Food ________	☐ Heart Defect/Disease	
☐ German Measles	☐ Hay Fever ________	☐ Seizures	
☐ Mumps	☐ Insect Stings ________	☐ Bleeding Disorders	☐ Tylenol/Acetaminophen
☐ Rheumatic Fever	☐ Medicine/Drugs ________	☐ Asthma	☐ Advil/Ibuprofen
☐ Tuberculosis	☐ Plants ________	☐ Hypertension	☐ Sudafed/Decongestant
☐ Kidney	☐ Pollen ________	☐ Diabetes	☐ Benadryl/Antihistamine
	☐ Other (specify) ________	☐ Musculoskeletal Disorders	☐ Pepto-Bismol
	________	☐ Arthritis	☐ Tums/Antacids
	________	☐ Sinusitis	☐ Robitussin/Expectorant
		☐ Other ________	

PLEASE DESCRIBE CONDITIONS AND GIVE DATES:

Operations or serious injuries ______________________
Hospitalizations ______________________
Other diseases/disabilities ______________________

COMMENTS WHERE APPLICABLE:

Fainting ______________________ Sleep disturbances ______________________
Bed wetting ______________________ Menstrual cramps ______________________
Constipation ______________________ Nosebleeds ______________________
Emotional disturbances ______________________ Other ______________________
Specific activities to be encouraged ______________________ Restricted ______________________
Special medical or dietary regimen to be followed (specify) ______________________

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted.

Signature of Parent/Guardian ______________________ Date ________

HEALTH INFORMATION PRIVACY STATEMENT

The **Girl Health History Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. Sybaquay Council will retain the health form until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but the participant or their legal representative may request copies from the event sponsor. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature of Parent/Guardian ______________________ Date ________