

242 Adelpia Road
Farmingdale, NJ 07727

1405 Old Freehold Road
Toms River, NJ 08753

Girl Scouts of the Jersey Shore

STANDARD HEALTH HISTORY/PERMISSION SLIP

To be filled in by parent/guardian.

Information is confidential and only provided to leader or chaperone in case of emergency.

_____(_____)_____
Girl's Name (Last, First, Initial) Home Phone # Birth date Age

_____(_____)_____
Parent/Guardian's Name Daytime Phone #

Address Town State Zip

_____(_____)_____
In Emergency Notify Address Daytime Phone #

Medical Insurance ID#

_____(_____)_____
Name of Pediatrician/Doctor Phone

Date of last physical exam: _____

Health History: (check those that apply)

Diseases

- Chicken Pox
- Measles
- German Measles
- Mumps

Allergies

- Animals
- Pollen
- Hay Fever
- Insect Stings
- Medicine/Drugs
- Plants
- Food *
- Other* (Specify)

Chronic or Recurring Illness

- Ear Infections
- Heart Defect/Disease
- Seizures – medication*
- Bleeding Disorders
- Asthma – inhaler*
- Hypertension
- Diabetes
- Musculoskeletal Disorders
- ADD
- Other* (Specify)_____

Authorization for treatment: *In the case of an emergency, I hereby give permission to the physician selected by the leader to secure and administer treatment, including hospitalization for my child as named above.*

Parent/Guardian signature _____ Date: _____

Continued on back

Please describe conditions and give dates:

Operations or serious injuries _____

Hospitalizations _____

Other diseases/disabilities _____

Does your child take any medication regularly? _____

If so, name of medication _____
for what condition? _____

Comments where applicable:

Fainting _____

Menses _____

Constipation _____

Nosebleeds _____

Emotional disturbances _____

Injuries _____

Other _____

Special medical or dietary regimen to be followed (be specific) _____

My child has permission to take Tylenol - Yes _____ No _____

Number of tablets _____ Child or Adult _____

Tylenol will be given in case of fever or headache. Parent will be notified if given.

Are there any additional concerns, medical or otherwise, you wish to bring to our attention? _____

This health history is correct and my child has permission to engage in all prescribed activities, except as noted by me.

Parent/Guardian signature _____ Date: _____

If no changes from prior year: Parent/Guardian initial _____ Date: _____

Parent/Guardian initial _____ Date: _____

Parent/Guardian initial _____ Date: _____