

Medical Form

Girl Name: _____

Does your daughter suffer from Anaphylaxis Yes No Does your daughter carry an Epipen? Yes No

**Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.*

Does your daughter carry an inhaler? Yes No

Allergies: Please list all allergies, type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/Severity	Treatment	Date of last Reaction

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects

Medications: List any medications she is currently taking (or has taken in the recent past) including dosage schedule and specific instructions for use. Also, please indication (Yes/No) if minor is allowed to take the medication on her own or if she should be monitored by the First Aider.

Medication	Purpose	Dosage Schedule	Specific Instructions	Self-Medicate (Yes/No)

Over-the-Counter Medications: My daughter has permission to take over-the-counter medications in case of accident or injury. Please check all that she has permission to take:

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Tylenol/Acetaminophen | <input type="checkbox"/> Aspirin (fever reducer) | <input type="checkbox"/> Ibuprofen (pain/swelling) | <input type="checkbox"/> Pepto Bismol |
| <input type="checkbox"/> Robitussin/expectorant | <input type="checkbox"/> Sudafed/decongestant | <input type="checkbox"/> Benadryl/Antihistamine | <input type="checkbox"/> Tums/antacid |
| <input type="checkbox"/> Imodium (anti/diarrhea) | <input type="checkbox"/> Dramamine (motion sickness) | <input type="checkbox"/> Skin Ointments (in case of rash, etc) | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | | |

Special considerations or notes: _____

Does your child have a Special Medical or Dietary Regiment to be followed? Yes No

If yes, please explain: _____

Any other information not covered in this form that is important for staff to know: _____

Signature of Caregiver: _____ Date: _____

Continued - PARTICIPANT INFORMATION – Girls, Non-Member Children, and Adults

	Troop #	First & Last Name	Address/Phone	Grade
11				
12				
13				
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23				
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25				

Return registration form to your local Girl Scouts – Dakota Horizons office.

Girl Scouts—Dakota Horizons

735 Airport Road
Bismarck, ND 58504
T 701.223.4525 or
1.800.326.4745
F 701.223.7840

Girl Scouts—Dakota Horizons

1002 43rd Street S
Fargo, ND 58103
T 701.293.7915 or
1.877.904.8168
F 701.293.7962

Girl Scouts—Dakota Horizons

1202 E St Francis Street
Rapid City, SD 57701
T 605.343.6355 or
1.800.658.3391
F 605.343.9508

Girl Scouts—Dakota Horizons

1101 S Marion Road
Sioux Falls, SD 57106
T 605.336.2978 or
1.800.666.2141
F 605.336.6841

Girl Scouts—Dakota Horizons

525 31st Avenue SW
Minot, ND 58701
T 701.852.5611 or
1.800.279.5306
F 701.838.1574

Girl Scouts—Dakota Horizons

2525 Demers Avenue
Grand Forks, ND 58201
T 701.772.6679 or
1.800.437.4399
F 701.772.6670