# Health & Permission Form

Girl Scout youth - to be completed and signed by parent/guardian
Adult – self complete

**Troop Use:** This form must be completed annually and as changes occur and returned to the troop leader.

**Dakota Horizons Council Use:** This form must be completed and submitted to council as requested for specific council activities (events or camps). Identify activities in Participation Section below.

girl scouts dakota horizons

| **Contact Information** | | |
|---|---|---|
| Child's Full Name: | Date of Birth: | Age: |
| Address: | | |
| Parent/Guardian Name: | Phone: | Email: |
| Emergency Contact: | Phone: | Relationship: |
| Emergency Contact: | Phone: | Relationship: |

| **Health Insurance Information** – In case of accident or illness, personal insurance is primary, Girl Scout insurance is secondary. | |
|---|---|
| Policy Holder Name: | Insurance Company: |
| Policy Number: | Group Number: |
| Preferred Hospital: | |
| Physician's Name: | Phone: |

| **Pick up information** – Name of person (s) authorized to pick up your child: | | |
|---|---|---|
| Name: | Phone: | Relationship to child: |
| | | |
| | | |
| Names of Person(s) NOT permitted to pick up your child: | | |
| | | |
| If applicable, can your child walk home? ☐ Yes ☐ No | | |

| **Participation in Dakota Horizons Council Activities** – complete as requested by council staff for participation in activities noted. | | |
|---|---|---|
| Event/Camp Name: | Session Date: | Location: |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

| **Medical History** – Check all that apply | | |
|---|---|---|
| ☐ Anxiety | ☐ Eyesight Impairment | ☐ Menstruation has started |
| ☐ Arthritis | ☐ Fainting / Dizzy Spells | ☐ Menstrual Cramps |
| ☐ Asthma | ☐ Headaches / Migraines | ☐ Musculoskeletal Disorders |
| ☐ Autism Spectrum Disorder | ☐ Hearing Impairment | ☐ Mental / Psychological Disorders |
| ☐ Bedwetting | ☐ Heart Defects/ Disease | ☐ Nosebleeds |
| ☐ Bleeding Disorder | ☐ Hernia | ☐ Sinusitis (Recurring Sinus Infections) |
| ☐ Convulsions /Epilepsy/Seizures | ☐ Hypertension / High Blood Pressure | ☐ Sleep Disturbances / Impairment |
| ☐ Diabetes | ☐ Intestinal Disorders / Constipation | ☐ Speech Impairment |
| ☐ Diseases of the Ear or Ear Infections | ☐ Kidney / Bladder Disease | ☐Surgery / Hospitalized in last 5 days |
| ☐ Eating Disorders | ☐ Learning Disorder | ☐ Under Physician / Psychologist care |
| ☐ Other: | ☐ Other: | ☐ Other: |
| Date of last health exam: | Were any complication medical problems noted in last health exam? ☐ Yes ☐ No | |
| Please explain in detail any items checked above: | | |
| My child's immunizations are up to date: ☐ Yes ☐ No, state reason(s): | | |
| DTP or DT (Tetanus) Date or Year: | | |

| **Allergies** - List ALL allergies (including medications, food, bees, etc.), the type of reaction/severity, treatment and date of last reaction. | | | |
|---|---|---|---|
| Allergies | Reaction/Severity | Treatment | Date of Last Reaction |
| | | | |
| | | | |
| | | | |
| | | | |
| Comments: | | | |
| Does your child suffer from Anaphylaxis?* ☐ Yes ☐ No<br>*A severe allergic reaction marked by swelling of the throat and/or tongue, hives, and trouble breathing.<br>Do they carry an EpiPen? ☐Yes ☐No Do they carry an inhaler? ☐Yes ☐No | | | |

## Over the Counter Medications & Dietary Restrictions

☐ My child can take the following over the counter medications daily or in case of accident/injury/sickness (for example pain reliever, digestive relief, etc.) Please include dosage as necessary. Check all that apply.

☐ My child does not have permission to take over the counter medication (please include any over the counter medication allergies above).

| | | |
|---|---|---|
| ☐ Tylenol / acetaminophen | ☐ Robitussin / expectorant | ☐ Imodium / anti-diarrhea |
| ☐ Aspirin / fever reducer | ☐ Sudafed / decongestant | ☐ Dramamine / motion sickness prevention |
| ☐ Ibuprofen / pain/swelling | ☐ Pepto Bismol | ☐ Other: |
| ☐ Benadryl / antihistamine | ☐ Tums / antacid | ☐ Other: |
| ☐ Skin Ointments / in case of rash, antibacterial, athlete's foot, etc. | ☐ Other: | ☐ Other: |

☐ I understand that all over the counter medications must be turned into the First Aider.

Special Consideration or Notes:

My child has the following dietary restrictions:

My child takes prescription medication: ☐ yes ☐ no If yes, complete Section 2 of this form.

## Initial & Sign

| | |
|---|---|
| | I understand that I am responsible for ensuring my child is picked up on time from meetings and activities. I understand that neither the volunteer nor Girl Scouts is responsible for driving them home or walking with them. |
| | I am the parent or guardian having legal custody of the child named above. I authorize all medical, surgical, diagnostic, and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital, when efforts to contact me are unsuccessful and when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment. I will take full responsibility for all charges that occur. Girl Scout insurance is secondary to your primary insurance. |
| | I know of no reason (s), other than the information indicated on this form, why my child should not participate in activities except as noted. |
| | Throughout the year, there will be meetings and field trips held outside the normal meeting space. Your signature will give permission for all of our group's local activities for field trips, including transportation of one day or less. If the leader does not hear from you prior to the event date, she/he will assume based on your signature below that your child has your permission to participate. |
| | I hereby release and hold harmless Girl Scouts – Dakota Horizons from any and all claims or liability arising from, out of, or associated with my child's participation in activities. My signature on this form evidencing my release of the council, its agents and employees. |

**Parent/Guardian Signature:** **Date:**

## Section 2 – Prescription Medication Form

**Prescription Medication**

List any medications including dosage schedule and specific instructions for use. ALL prescriptions must be in the original container with the appropriate label. *If traveling, please provide extra written prescription(s) from the doctor with the generic name for all medications in case the original prescription is lost or a new one needs to be obtained.*

| Medical Condition | Medication | Dosage | Dosage instructions (When and How often) | Special Storage Requirements |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Other:

Special considerations or notes:

**Parent/Guardian Signatures** – Initial and Sign

| | |
|---|---|
| | I am the parent/legal guardian of _____, a registered Girl Scout who has a medical condition that requires that she take prescription medication. Throughout the course of the year, my child also may take over-the-counter medications as needed. Because I will be unable to be with them at the time they need to take prescription I give___[name of troop leader/authorized volunteer/GSDH staff] permission to administer the following medication to my child or legal ward according to the instructions of their medical provider: |

Signature: Printed Name:

Phone Number: Email: