Medical Form

Girl Scout youth - to be completed and signed by parent/guardian

girl scouts dakota horizons

Contact Information
Child's Full Name:

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

Does your child suffer from Anaphylaxis?* ☐ Yes ☐ No

*A severe allergic reaction marked by swelling of the throat and/or tongue, hives, and trouble breathing.

Do they carry an EpiPen? ☐Yes ☐No Do they carry an inhaler? ☐Yes ☐No

Medical Conditions – Include any precautions or restrictions on activities.

Name of Condition	Effects

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.

My child has the following dietary restrictions:

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

Signature: Printed Name:

Phone Number: Email:

Section 2 – Prescription Medication Form