girl scouts of hawai`i

Membership Year ____

Health History Form

To be completed, signed, and returned to Council office no later than **3 weeks** prior to activity. Email to: customercare@gshawaii.org or mail to: GSH, ATTN: Programs, 1164 Bishop Street, Suite 200 Honolulu HI 96813. All information, releases, and authorizations given in this document are for the membership year as noted above. Parent/legal guardian is responsible for notifying Council/troop leader in writing of any changes in this information. Council/troop leader will keep the form with them at all council/troop functions.

Section 1: Participant Information

Full Legal Name: _____ Camp Name: _____ Troop #: _____

Date of Birth: _____ Age: _____ ◯ Girl Scout ◯ Adult T-Shirt Size:

Address: _____

Custodial Parent/Guardian if Under 18: _____ Best Phone #: _____

Address (if different from Participant's address): _____

Emergency Contact: _____ Best Phone #: _____

Authorized Adults for Pick-up / Drop-off: _____ Best Phone #: _____

Section 2: Health Conditions, Past & Present *(Check all that apply)*

Please list and describe all health conditions, past and present:

Date of last health examination:	**Were any medical problems noted in last medical exam?** ◯ Yes ◯ No

Since last health exam, has participant had:

☐ A serious injury requiring medical attention?	☐ Treatment in a hospital or emergency room?
☐ A surgical procedure or fracture?	☐ Any exposure to a contagious disease?

Does participant have any restrictions concerning physical activities? ◯ Yes *(Explain)* ◯ No

Section 3: Allergies

Allergy	Reaction / Severity	Treatment	Date of Last Reaction

Does participant suffer from Anaphylaxis?* ◯ Yes ◯ No **A severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing*

Does participant carry an Epipen? ◯ Yes ◯ No **Does participant carry an inhaler?** ◯ Yes ◯ No

Section 4: Physician/Dentist, Hospital, and Insurance Information

Physician Name: _____ Phone #: _____ Preferred Hospital: _____

Medical Insurance Carrier Name: _____ Insurance #: _____

Dentist Name: _____ Phone #: _____

Dental Insurance Carrier Name: _____ Insurance #: _____

☐ I do not have medical insurance coverage

Section 5: Immunizations *(Indicate "as child" if you do not have a record of dates / leave blank if none apply)*

Immunization	Primary Series	Last Booster	Date of Last Reaction
☐ **Participant has not received any immunizations**			
Covid-19			
Tetanus			

Participant may receive Tetanus shot if necessary. ◯ Yes ◯ No

Section 6: Prescription Medicine* *(List any medications including dosage schedule and specific instructions)*

Medication	Purpose	Dosage	Specific Instructions

***ALL prescriptions must be in the original container with appropriate label.**

Section 6.2: Over-the-counter Medication *Participant has permission take the following in case of accident or injury:*

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

Special considerations or notes:

I have reviewed the policy on administering medication to a minor and submitted the appropriate permission forms to the adult in charge.

◯ Yes ◯ No ◯ N/A *(My child is not currently taking any prescribed or over-the-counter medications)*

Participant has the following dietary restrictions:

Section 7: Signatures *(A separate form for each minor or adult is required)*

For Custodial Parents/Guardians: This health history is correct and I am able to participate in all prescribed activities except as noted.

For Adults: This health history is correct and I am able to participate in all prescribed activities except as noted.

Signature	**Date**

Section 8: Authorization of Consent for Emergency Treatment

I AUTHORIZE EMERGENCY TREATMENT AT THIS SPECIAL EVENT ◯ Yes ◯ No

Participant has permission to attend the regular scheduled meetings and special activities of Troop #_____ and council functions of the Girl Scouts of Hawai'i. If an emergency occurs while attending or traveling to or from regular meetings or special trips/activities and I cannot be reached to give consent for medical care, I hereby authorize or do not authorize the group leader/adult-in-charge or in their absence or disability, any adult accompanying or assisting the group leader/adult-in-charge, to seek treatment for myself or my child and/or dependent minor by a first aid certified person or a licensed physician. I know of no reason(s), other than the information indicated on this form, why I/my child/dependent should not participate in prescribed trip/activities except as noted above.

Signature	**Date**

Section 9: Media Release

I hereby consent/or do not consent that the videotapes, photographs, motion pictures, electronic images, and/or audio recordings of Participant may be used by Girl Scouts for Public Relations and Publicity purposes. ◯ Yes ◯ No

I acknowledge that I am eighteen (18) years of age or older or am a legal guardian of this Participant. I hereby grant to the Girl Scouts of the USA ("GSUSA"), and others working for GSUSA or on its behalf, Girl Scouts of Hawai'i council, and each of its respective licensees, successors and assigns (each a "Releasee"), the irrevocable, royalty-free, perpetual, unlimited right and permission to use, distribute, publish, exhibit, digitize, broadcast, display, modify, create derivative works of, reproduce or otherwise exploit her first name/last initial (only), picture, likeness and voice (including any video footage of the same), testimonials and interviews (written by her or attributed to her), (collectively, "Media"), or to refrain from doing so, anywhere in the world, by any persons or entities deemed appropriate by GSUSA and Girl Scouts of Hawai'i council, for any purpose including, without limitation, any use for educational, advertising, non-commerical or commercial purposes in any manner or media whatsoever (whether known or hereafter devised) including, without limitation, on the internet, in print campaigns, in-store and via television.

Signature	**Date**

Section 10: Permission to Participate in Product Sales

My child has permission to participate in the Girl Scout Cookie Program. ◯ Yes ◯ No

I agree and accept full financial responsibility for all products and money she receives. I understand that she must have adult guidance at all times when participating in the Girl Scout Cookie Program. I further understand that my child may not take orders before the official start date as determined by Girl Scouts of Hawai'i, and money will not be collected until cookies are delivered to customers. All past due accounts, if any, may be sent to a collection agency, which may affect my credit rating. I am responsible for full payment of the face amount of my personal checks and an additional service charge of $25 for any of my checks returned by my bank for insufficient funds regardless of the reason for the lack of funds. All proceeds received from the Girl Scout Cookie Program are troop and Council funds and NOT the property of my Girl Scout. Juliettes who participate in the Cookie Program are eligible to earn girl rewards.

Signature	**Date**