

Procedure for Collecting Health Histories

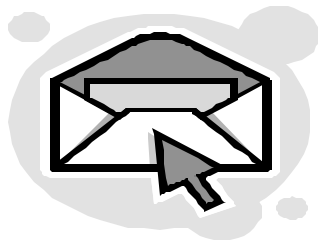
The GSUSA girl and adult membership forms do not have a health history section due to concerns regarding the Privacy of Information Act.

Having information about allergies and special needs is an important aspect of providing a safe environment in Girl Scouting.

We encourage leaders to use this Health History record for all members: girls and adults. Because the information provided is confidential, the following is a procedure for use:

1. *At the beginning of the membership year*, the parents, or guardians of the girls and the adults complete a Health History record.
2. The Leader or Group First Aider reviews the information in order to be aware of any special needs or allergies to be kept in mind in planning trips, meetings, or other Girl Scout events.
3. After review, the Health History Record is placed in a sealed envelope with the persons name on it to be opened only in the event the information is needed.
4. The sealed envelopes are brought to every activity in which the members participate. If girls and adults are riding in a vehicle, the driver of the car should have all the sealed envelopes.
5. *At the end of the membership year*, the Health History Records should be shredded to protect the privacy of all individuals.

Any questions about the retention or use of the Health History Record should be directed to the Operational Vice President of Regional Services.



Girl Scouts of Swift Water Council
P.O. Box 10832
Bedford, NH 03110-0832

HEALTH HISTORY RECORD

GIRL

Check one

ADULT

In order for your daughter to have a fun and safe experience in Girl Scouting, we request the following information. Your daughter's leader will review this form; prior permission will be obtained before this information is shared with others. Complete and sign this history; please print:

Name: _____ Telephone _____

Street Address: _____

City: _____ State: _____ Zip: _____

Check all that apply and give dates. Explain any checked items below:

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Bleeding/Clotting disorders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Defect or Disease |
| <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other (specify): _____ | | |

Date of last health examination: _____ Date of last tetanus _____

List all prescription medications (dosage and frequency):

Allergies: Check all that apply and specify nature of allergy:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Pollen _____ |
| <input type="checkbox"/> Medicines/Drugs _____ | <input type="checkbox"/> Plants _____ |
| <input type="checkbox"/> Hay fever _____ | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Insect bite/sting _____ | <input type="checkbox"/> Other _____ |

Other Health conditions: Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Sickle Cell trait/disease |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Glasses or contact lenses | <input type="checkbox"/> Special diet regimen |
| <input type="checkbox"/> Other _____ | |

Please explain checked items: _____

Emergency Contact: _____

Telephone: _____ Relationship: _____

Signature: _____ Date: _____

Parent/Guardian Adult self

Girl Scouts of Swift Water Council, P. O. Box 10832 / One Commerce Drive, Bedford, NH 03110-0832

HISTORIA MÉDICA

NIÑA

(Escoje Una)

ADULTO

Para que su hija tenga una experiencia divertida y segura solicitamos la información que sigue a continuación. La líder del grupo de su hija revisara la planilla, se pedirá su autorización antes de compartir esta información con otras personas. Llene y firme por favor esta planilla en letra de imprenta.

Nombre: _____ Teléfono: _____

Dirección: _____

Ciudad: _____ Estado: _____ Zona: _____

Indique lo que aplique a usted y favor explicar abajo:

Sangramiento/Problemas de coagulación sanguínea Asma Defecto/Enfermedad Cardíaco

Problemas musculares u ortopédicos Ataques epilépticos Diabetes/Hipoglicemia

Otro (especifique): _____

Fecha de exámen medico más reciente: _____

Año en que se inoculó contra el tétano: _____

Anota todas las medicinas que toma diariamente: _____

Alergias (Marque las que correspondan y explique el tipo de reacción alérgica):

Animales: _____ Polen: _____

Medicamentos: _____ Plantas: _____

Fiebre del heno (hay fever): _____ Alimentos: _____

Picaduras de insectos: _____ Otras (especifique): _____

Otras condiciones médicas: (Marque los que correspondan):

Se mareo en vehiculos Problemas de audición

Usa lentes or lentes de contacto Anemia (sickle cell)

Problemas de aprendizaje Régimen dietético especial

Otro (especifique): _____

Favor de explicar lo que marcó arriba: _____

En caso de emergencia, llamar a: _____

Relación: _____ Teléfono: _____

Firma del Padre, Madre, o Tutor / Su Firma

Fecha