girl scouts of southern nevada

Girl Health History Record

All information will be kept confidential

Name:_____
Last First M.I.

Address:_____City/St/Zip_____

Date of Birth:_____/_____/_____ Age:_____ Grade:_____ Phone: (_____)_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name:_____ Relationship:_____

Address:_____ Phone: (_____) _____

Physician's Name:_____ Phone: (_____) _____

Date of last health exam:_____

Insurance Provider:_____ Policy/Group #:_____

Insured's Name:_____ Relationship:_____

Have you ever been hospitalized in the last five years? ❍Yes ❍No Are you taking any medications? ❍Yes ❍No

If yes, explain:_____

Please indicate if you have had any of the following: ✓			
	Eyesight Impairment		Heart Disease
	Hearing Impairment		Rheumatic Fever
	Speech Impairment		Blood Pressure Disorders
	Nervous System Disorders		Mental/Emotional Disorders
	Sinusitis		Frequent Ears Infections
	Kidney Disease		Severe Menstrual Pain
	Arthritis		Intestinal Disorders
	Diabetes		Bleeding/Clotting Disorders
	Tuberculosis		Seizures
	Hernia		Hypoglycemia
	Asthma		Bedwetting
	Eye Impairment		Hearing Impairment
	ADHD		
Other :			
Special Needs:			
Dietary Needs:			

My daughter's health history and special needs are correct to the best of my knowledge and she is able to engage in all activities, except as noted.

Signature _____ Date _____

Record of Immunization	Year Primary Series Completed	Year of Last Booster
DTaP		
Diphtheria		
Pertussis (Whooping Cough)		
Tetanus (within last 10 years)		
Td		
Oral polio/IPV		
Measles		
Mumps		
Rubella		
Hib		
Hep B		
Tuberculin test Yr. last given_____ Result_____		
Other		
Typhoid and		
Paratyphoid		
Cholera		
Yellow Fever		
Typhus		
Rocky Mountain		
Spotted Fever		