

its officers or leaders.

Signature:

## Health History Form

All information will be kept confidential.

ADHD Arthritis Bedwetting Bleeding/Clotting Disorders  Blood Pressure Disorders Chicken Pox Diabetes Disease of Ears/Frequent Ear Infection Eyesight Impairment German Measles Hayfever/Asthma Hearing Impairment Heart Disease Hearing Impairment Heart Disease Hearing Impairment Heart Disease Measles Hearing Impairment Heart Disease Measles Measles Mematal/Emotional Disorders Mumps Nervous System Disorders Rheumatic Fever Seizures Severe Menstrual Pain Sinusitis Speech Impairment Tuberculosis Visual Impairment  Other Serious Allergies:  Special Needs:  Dietary Needs:  The above health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.  Person/Caregiver Signature:  Date:  PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE  In the event (Girl or Adult Listed Above) becomes ill or sustain an injury while in the care of or under the supervision of Girl Scouts of Southern Nevada or any of its officers or leaders, I authorize First Aid to be administered. If it should become necessary to s professional medical treatment, I give my permission for a licensed medical professional to administer any medical and/or surgical treatment she/he deenecessary, including hospitalization. I understand that every effort will be made to contact the party listed under "Emergency Contact." I accept full finan responsibility for all expenses incurred that are not covered by Girl Scout Activity insurance.					
Address:	Name:	Loot	Finat	M1	
In CASE OF EMERGENCY, PLEASE NOTIFY:	Address				
In Case OF EMERGENCY, PLEASE NOTIFY:  Emergency Contact Name: Relationship:  Address: Phone:  Physician's Name: Physician's Phone:  Insurance Provider: Policy/Group #:  Insured's Name: Relationship to Insured:  Medical History  Has the person listed been hospitalized in the last five years? □Ves □ No Is the person listed daking any medications? □Ves □ No If yes, please explain:  Is the person listed due with immunizations? □Ves □ No If no, is the person exempt for □ religious or □ medical reasons? (Please check one)  Please indicate if if the person listed has had any of the following: ✓  ADHD Arthritis Bedwetting Bloeding/Clotting Disorders  Blood Pressure Disorders Chicken Pox Diabetes Disease of Ears/Frequent Ear Infectit Byesight Impairment German Measles Hayfever/Ashtma Hearing Impairment  Heart Disease Hearing Haypoglycemia Intestinal Disorders  Kidney Disease Measles Mental/Emotional Disorders Mumps  Nervous System Disorders Rheumatic Fever Selzures Severe Menstrual Pain  Other Serious Allergies:  Special Needs:  Dictary Needs:  Dictary Needs:  Person/Caregiver Signature: Date:  PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE  In the dove health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.  Person/Caregiver Signature: Date:  PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE  In the over (Girl or Adult Listed Above) becomes Ill or sustain an injury while in the care of or under the supervision of Girl Scouts of Southern Nevada or any of its officers or leaders, lauthorize First Ald to be administered, it is should become necessary to s professional medical treatment, I give my permission for a Icensed medical professional to administer any medical and/or surgical treatment reponsibility for all expenses incurred that are not covered by Girl Scout Activity insurance.					
Emergency Contact Name:  Address:  Phone:  Physician's Name:  Physician's Phone:  Insurance Provider:  Insurance P	Gender Date	e of Birth:///	Phone: ()		
Address: Physician's Name: Physician's Phone: Physician's Phone: Insurance Provider: Policy/Group #: Insurance Provider: Policy/Group #: Insurance Provider: Relationship to Insured:  Medical History Has the person listed been hospitalized in the last five years?   Yes   No   Is the person listed taking any medications?   Yes   No   If yes, please explain: Is the person listed up to date with immunizations?   Yes   No   If no, is the person listed up to date with immunizations?   Yes   No   If no, is the person listed has had any of the following: / ADHD   Anthritis   Bedwetting   Bleeding/Clotting Disorders   Blood Pressure Disorders   Chicken Pox   Diabetes   Disease of Ears/Frequent Ear Infectite   Eyesight Impairment   German Measles   Harfiever/Ashtma   Hearing Impairment   Heart Disease   Measles   Mental/Emotional Disorders   Mumps   Nervous System Disorders   Rheumatic Fever   Seizures   Severe Menstrual Pain   Sinusitis   Speech Impairment   Tuberculosis   Visual Impairment   Other Serious Allergies: Special Needs: Dietary Needs:  The above health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.  Person/Caregiver Signature:   Date:    PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE   In the event (Girl or Adult Listed Above)   becomes ill or sustain an injury while in the care of or under the suspervision of Girl Scouts of Southern Nevada or any of its officers or leaders, a luthorize First Aid to be administered. If it should become necessary to s professional medical treatment, 1 give my permission for a license medical treatment the party listed under "Emergency Contact." I accept full finan responsibility for all expenses incurred that are not covered by Girl Scout Activity insurance.	IN CASE OF EMERGENCY, PL	EASE NOTIFY:			
Physician's Name:    Insurance Provider:	Emergency Contact Name:		Relationship:	Relationship:	
Insured's Name:    Relationship to Insured:	Address:		Phone:	Phone:	
Relationship to Insured:	Physician's Name:		Physician's Phone:		
Medical History	Insurance Provider:		Policy/Group #:		
Has the person listed been hospitalized in the last five years?   Yes   No Is the person listed taking any medications?   Yes   No If yes, please explain:   Is the person listed up to date with immunizations?   Yes   No If no, is the person exempt for   religious or   medical reasons? (Please check one)    Please indicate if if the person listed has had any of the following: \( \sqrt{2} \)   Anthritis   Bedwetting   Bleeding/Clotting Disorders	Insured's Name:		Relationship to Insured	Relationship to Insured:	
Heart Disease Hernia Hypoglycemia Intestinal Disorders Kidney Disease Measles Mental/Emotional Disorders Mumps Nervous System Disorders Rheumatic Fever Seizures Severe Menstrual Pain  Sinusitis Speech Impairment Tuberculosis Visual Impairment  Other Serious Allergies:  Special Needs:  Dietary Needs:  Dietary Needs:  Dietary Needs:  Person/Caregiver Signature:  PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE  In the event (Girl or Adult Listed Above)  Specylasion of Girl Scouts of Southern Nevada or any of its officers or leaders, I authorize First Aid to be administered. If it should become necessary to sprofessional medical treatment, I give my permission for a licensed medical professional to administer any medical and/or surgical treatment she/he decencessary, including hospitalization. I understand that every effort will be made to contact the party listed under "Emergency Contact." I accept full finant responsibility for all expenses incurred that are not covered by Girl Scout Activity Insurance.	ADHD Blood Pressure Disorders	Arthritis Chicken Pox	Diabetes	Disease of Ears/Frequent Ear Infections	
Kidney Disease Measles Mental/Emotional Disorders Mumps Nervous System Disorders Rheumatic Fever Seizures Seizures Severe Menstrual Pain  Sinusitis Speech Impairment Tuberculosis Visual Impairment  Other Serious Allergies:  Special Needs:  Dietary Needs:  The above health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.  Person/Caregiver Signature:  Date:  PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE  In the event (Girl or Adult Listed Above)  becomes ill or sustain an injury while in the care of or under the supervision of Girl Scouts of Southern Nevada or any of its officers or leaders, I authorize First Aid to be administered. If it should become necessary to s professional medical treatment, I give my permission for a licensed medical professional to administer any medical and/or surgical treatment she/he decencessary, including hospitalization. I understand that every effort will be made to contact the party listed under "Emergency Contact." I accept full finan responsibility for all expenses incurred that are not covered by Girl Scout Activity Insurance.	· · · ·				
Nervous System Disorders  Rheumatic Fever  Seizures  Seizures  Severe Menstrual Pain  Visual Impairment  Other Serious Allergies:  Special Needs:  Dietary Needs:  The above health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.  Person/Caregiver Signature:  Date:  PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE  In the event (Girl or Adult Listed Above)  becomes ill or sustain an injury while in the care of or under the supervision of Girl Scouts of Southern Nevada or any of its officers or leaders, I authorize First Aid to be administered. If it should become necessary to s professional medical treatment, I give my permission for a licensed medical professional to administer any medical and/or surgical treatment she/he dee necessary, including hospitalization. I understand that every effort will be made to contact the party listed under "Emergency Contact." I accept full finan responsibility for all expenses incurred that are not covered by Girl Scout Activity Insurance.					
Sinusitis  Speech Impairment  Tuberculosis  Visual Impairment  Other Serious Allergies:  Special Needs:  Dietary Needs:  The above health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.  Person/Caregiver Signature:  Date:  PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE  In the event (Girl or Adult Listed Above)  becomes ill or sustain an injury while in the care of or under the supervision of Girl Scouts of Southern Nevada or any of its officers or leaders, I authorize First Aid to be administered. If it should become necessary to s professional medical treatment, I give my permission for a licensed medical professional to administer any medical and/or surgical treatment she/he dee necessary, including hospitalization. I understand that every effort will be made to contact the party listed under "Emergency Contact." I accept full finan responsibility for all expenses incurred that are not covered by Girl Scout Activity Insurance.	·			'	
Special Needs:  The above health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.  Person/Caregiver Signature:	Sinusitis		Tuberculosis	Visual Impairment	
Dietary Needs:  The above health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.  Person/Caregiver Signature:					
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	PERI				
Signature: Date:	In the event (Girl or Adult Listed Above supervision of Girl Scouts of Souther professional medical treatment, I give necessary, including hospitalization.	n Nevada or any of its officers or lead e my permission for a licensed medica understand that every effort will be r	ers, I authorize First Aid to be administe al professional to administer any medic made to contact the party listed under	ered. If it should become necessary to see cal and/or surgical treatment she/he deem	

Date:

I do not desire the authorization and understand that in doing so I release and relieve for all liability whatsoever Girl Scouts of Southern Nevada,