Girl Scouts Heart of New Jersey
Girl Health History Record

PLEASE PRINT - TO BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN OF GIRL - SU# ______ Troop# _________

Girl's Name ____ Birth Date ____________________

Address ____
Street Apt. # City State Zip

Telephone ______________________________ School ______________________________

Troop Leader's Name ______________________________ Telephone ____________________

Mother's Name ______________________________ Day Time Telephone ____________________

Father's Name ______________________________ Day Time Telephone ____________________

Name of family DENTIST: ______________________________ Telephone ____________________

Name of family PHYSICIAN: ______________________________ Telephone ____________________

Family Medical/Hospital INSURANCE CARRIER ____________________ Policy or Group # ____________________

Part I: Illnesses and Injuries (check all for which treatment has been received and give appropriate dates)

□ Asthma __________
□ Diabetes __________
□ Hypertension __________
□ Bleeding/Clotting Disorders __________
□ Ear Infection __________
□ Lung Disease __________
□ Conditions of the bones or joints __________
□ Epilepsy __________
□ Kidney Disease __________
□ Convulsions __________
□ Heart Defect/Disease __________
□ Other (specify) ____

Date of last health examination ____________________ Were any complicated medical problems noted? □ Yes □ No

If yes, please explain ____

Part II: Allergies (Check those that apply and treatment) □ **Check Here for No Known Allergies**

□ Animals ________________
□ Medicines/Drugs ________________
□ Food ________________
□ Plants ________________
□ Hay Fever ________________
□ Pollen ________________
□ Insect Stings ________________
□ Other (specify) ______________________________

(Please complete the back of this form.)

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(Please complete the back of this form.)

Part III: Other Health Conditions (Check those that apply)

□ Attention Deficit Disorder (ADD)	□ Hearing Impairment	□ Sleep Disturbances
□ Bed Wetting	□ Menstrual Cramps	□ Special Dietary Needs
□ Dental Braces	□ Motion Sickness	□ Visual Impairment
□ Down's syndrome	□ Nosebleeds	□ Wears Glasses or Contact Lenses
□ Emotional Disturbances	□ Obesity	□ Wears Hearing Aid
□ Fainting	□ Sickle Cell Trait or Disease	□ Other (specify) ______________________________

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
DPT -Diphtheria/Pertussis (Whooping Cough)/Tetanus	________________________	______________
Td	________________________	______________
Measles	________________________	______________
Mumps	________________________	______________
Rubella	________________________	______________
Oral Polio	________________________	______________
Hbpv	________________________	______________

Tuberculin Test (most recent) Result __________ Other (specify)____

EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN: MUST HAVE 2

Name ____________________________ Day/Evening Telephone ____________________ Relationship _____________

Name____________________________ Day/Evening Telephone ____________________ Relationship _____________

Activity Restrictions ____

I know of no reason(s) other than those indicated on this form, why my child should not participate in general Girl Scout activities, except as noted.

Signature: ____ Date________________________

Montclair Service Center	North Branch Service Center	Westfield Service Center
(973)746-8200	(908)72501226	(908)232-3236

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