



Girl Health History Record

Montclair · North Branch · Westfield · www.gshnj.org

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)

- | | | |
|------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Bleeding/Clotting Disorders _____ | <input type="checkbox"/> Ear Infection _____ | <input type="checkbox"/> Lung Disease _____ |
| <input type="checkbox"/> Conditions of the bones or joints _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Heart Defect/Disease _____ | |
| <input type="checkbox"/> 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

- | | | |
|----------------------------------------------|------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Medicines/Drugs _____ | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Plants _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Pollen _____ |
| <input type="checkbox"/> Insect Stings _____ | <input type="checkbox"/> 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)

- | | | |
|-----------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Special Dietary Needs |
| <input type="checkbox"/> Dental Braces | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Down's syndrome | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Wears Glasses or Contact Lenses |
| <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Obesity | <input type="checkbox"/> Wears Hearing Aid |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sickle Cell Trait or Disease | <input type="checkbox"/> Other (specify) _____ |

Part IV: Immunization History

<u>Immunization</u>	<u>Year Primary Series Completed</u>	<u>Year of Last Booster</u>
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
(973)746-8200
2/10

North Branch Service Center
(908)72501226

Westfield Service Center
(908)232-3236

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

- | | | |
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