girl scouts
of gateway council

Health Information - Minor

Must be completed and signed by parent or legal guardian

Child's full name: _____ Troop number: _____

Child's date of birth: _____ Child's height: _____ Child's weight: _____

List any health conditions or allergies: _____

_____

_____

List any medication currently taking: _____

_____

Primary physician: _____ My child's last physical exam was on: _____

Physician address: _____ Phone: _____

Does your child have health insurance? _____

My child has my permission to (check if yes):

SWIM ____ HIKE ____ CANOE/BOAT ____ RIDE HORSEBACK ____ CAMP ____

List any physical restrictions: _____

_____

Primary contact: _____ Cell: _____

Address: _____ Home: _____

Emergency contact: _____ Phone: _____

Emergency contact: _____ Phone: _____

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AUTHORIZATION FOR MEDICATION

The following is a list of medications commonly found in troop/community first aid kits. Please check with medications may be used to treat your child if necessary. Any medication you do not indicate as being acceptable for your child will not be used to treat your child.

First aid ointment____ Acetominophen____ Pepto-Bismol____ Antihistimine____

Hydrogen peroxide____ Bug repellent____ Antacid____ Ibuprofen____

Ear drops
(alcohol and water)____ Sunscreen____ Epsom salt____

Special instructions: _____

AUTHORIZATION TO TREAT A MINOR/ADMINISTER MEDICATION

I, the parent or legal guardian of _____, a minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment rendered by a licensed physician or under the general or special supervision of any member of the medical staff and emergency room staff of a duly licensed hospital in the United States and Canada. I further authorize Girl Scouts of Gateway Council representative to select a medical doctor and/or hospital of his or her choice for the purpose of diagnosis or treatment of the above named minor.

It is understood that this authorization is given in advance of any specific authority and power to render care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the above named minor, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is valid only for treatment of emergencies when the undersigned is not reasonably available to give consent.

Name: _____ Date: _____

Signature: _____