

Health Information - Minor

Must be completed and signed by parent or legal guardian

Child's full name: _____

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_____	Acetaminophen_____	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: _____