IF ATTENDING A SUMMER RESIDENT CAMP PROGRAM, USE THE O THIS FORM WILL BE USED FOR TROOP CAMPING, MINICAMPS, TRAVEL, ETC.



Health History & Consent Form

Contact #1 Name:	girl scou of utah		th Histo	ory & Conse	nt Form	Program D	ate:	Program Name:			
Address: City: State: Zip Code:		,		A)							
Preferred Phone Number: If a minor: Parent/Guardian #1 Name: Address: Cell Phone: Address: Cell Phone: Alternative Phone: Alternative Phone: Relationship to Participant: Cell Phone: Alternative Phone: Invalidation or Health Care Facility: Phone Number: INSUBANCE INFORMATION Insurance Company: Members Services Phone: INSUBANCE INFORMATION Insurance Company: Members Services Phone: Invalidation or Health Care Facility: Name of Physician or Health Care Facility: Name of Physician or Health Care Facility: Name of Physician or Health Care Facility: Insurance Company: Members Services Phone: Insurance Company: Insurance Company: Name of Insured: Insurance Company: Insurance Comp											
If a minor: Parent/Guardian #1 Name: Name: Address: Address: Address: Cell Phone: Alternative Phone: Phone Physician or Health Care Facility: Phone Number: ID Number: Alternative Phone: ID Number: Alternative Phone: Alternative Phon	Address:			•							
Name: Address: Cell Phone: Alternative Phone: Relationship to Participant: Cell Phone: Alternative Phone: Physician or Health Care Facility Name of Physician or Health Care Facility: Phone Number: Name of Physician or Health Care Facility: NSURANCE INFORMATION Insurance Company: Members Services Phone: ID Number: HEALTH INFORMATION Invol.1—CandilWA1—Can	Preferre	d Phone Number:			Second Preferred Ph	one Numb	er:				
Cell Phone:	If a mino				•						
Alternative Phone: Alternative Phone:		Address:			Addres						
Alternative Phone: Alternative Phone:		Cell Phone:			Cell Ph	one:					
EMERGENCY CONTACT INFORMATION (If participant is a minor, please list a non-parent/guardian contact) (NW31-0 and HW41-8) Contact #2 Name: Name:		Alternative Phone:			Alterna	ative Phon	e:				
Cell Phone: Alternative Phone: Alternative Phone: Alternative Phone: Alternative Phone: PPYSICIAN OR HEALTH CARE FACILITY Name of Physician or Health Care Facility: Phone Number: Name of Physician or Health Care Facility:	EMERGEN Contact i Name:	ICY CONTACT INFORMAT #1	ΓΙΟΝ (If partic	ipant is a minor, please	list a non-parent/guard Contact Name:	dian conta t #2	act) (HW.3.1	– D and HW.4.1 – B)			
Alternative Phone:	Relations	ship to Participant:			Relatio	Relationship to Participant:					
PHYSICIAN OR HEALTH CARE FACILITY Name of Physician or Health Care Facility: Name of Physician or Health Care Facility:	Cell Phor	ne:			Cell Ph	Cell Phone:					
PHYSICIAN OR HEALTH CARE FACILITY Name of Physician or Health Care Facility: Phone Number:											
HEALTH INFORMATION (HW.1.1 - CE and HW.4.1 - C) Check "Yes" or "No" for each statement. Explain "Yes" answers below and explain any accommodations needed. 1. Asthma? Yes No 13. Sleeping disorder/sleep walking? Yes No 25. Visual disability? Yes Diabetes? Yes No 14. Heart defect/disease? Yes No 26. Deaf/hard of hearing? Yes Seizures/epilepsy? Yes No 15. Bleeding/clotting disorders? Yes No 27. Behavioral problems? Yes Frequent ear infections? Yes No 16. Hypertension? Yes No 28. Eating disorder? Yes No 28. Frequent sore throats? Yes No 17. Recent infectious disease? Yes No 29. Has this person menstruated? Yes No 18. Chronic/reoccurring illness? Yes No a. If not, has she been told about it? To Bronchitis? Yes No 19. Skin conditions? Yes No b. If so, is her menstrual history nor 9. Stomach upsets? Yes No 21. Autism Spectrum Disorder? Yes No 30. Operations/serious injuries? Yes No 22. Emotional disability? Yes No 31. Other diseases/conditions? Yes No Explanation of "Yes" answers (use another sheet of paper if needed): RECORD OF IMMUNIZATIONS FOR GIRL MEMBERS (HW.1.1 - D)	Name of	Physician or Health Care	Facility:								
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2. Diabetes? Yes No 14. Heart defect/disease? Yes No 26. Deaf/hard of hearing? Yes 3. Seizures/epilepsy? Yes No 15. Bleeding/clotting disorders? Yes No 27. Behavioral problems? Yes No 16. Hypertension? Yes No 28. Eating disorder? Yes No 28. Faint disorder? Yes No 17. Recent infectious disease? Yes No 29. Has this person menstruated? Yes Sinusitis? Yes No 18. Chronic/reoccurring illness? Yes No a. If not, has she been told about it? No 19. Skin conditions? Yes No b. If so, is her menstrual history nor 9. Stomach upsets? Yes No 21. Autism Spectrum Disorder? Yes No 30. Operations/serious injuries? Yes No 22. Emotional disability? Yes No 31. Other diseases/conditions? Yes No 24. Physical disability? Yes No 31. Other diseases/conditions? Yes No Explanation of "Yes" answers (use another sheet of paper if needed):	Check "Y	es" or "No" for each stat	ement. Explai		· · · · · · · · · · · · · · · · · · ·						
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4. Frequent ear infections? Yes No 16. Hypertension? Yes No 28. Eating disorder? Yes Frequent sore throats? Yes No 17. Recent infectious disease? Yes No 29. Has this person menstruated? Yes 6. Sinusitis? Yes No 18. Chronic/reoccurring illness? Yes No a. If not, has she been told about it? 7. Bronchitis? Yes No 19. Skin conditions? Yes No 4. If not, has she been told about it? Yes Fainting/dizziness? Yes No 20. ADD/ADHD? Yes No 5. If so, is her menstrual history nor 9. Stomach upsets? Yes No 21. Autism Spectrum Disorder? Yes No 30. Operations/serious injuries? Yes 10. Constipation/diarrhea? Yes No 22. Emotional disability? Yes No 30. Operations/serious injuries? Yes 11. Bed wetting? Yes No 23. Learning disability? Yes No 31. Other diseases/conditions? Yes No 24. Physical disability? Yes No Solutions? Yes No 25. Explanation of "Yes" answers (use another sheet of paper if needed):					="				Yes Yes	No No	
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7. Bronchitis? Yes No 19. Skin conditions? Yes No Yes No 5. If so, is her menstrual history nor 9. Stomach upsets? Yes No 21. Autism Spectrum Disorder? Yes No 5. If so, is her menstrual history nor 9. Constipation/diarrhea? Yes No 22. Emotional disability? Yes No 30. Operations/serious injuries? Yes 11. Bed wetting? Yes No 23. Learning disability? Yes No 31. Other diseases/conditions? Yes 12. Urinary tract infections? Yes No 24. Physical disability? Yes No Solutions? Yes No 25. Explanation of "Yes" answers (use another sheet of paper if needed):		·						=	Yes	No	
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9. Stomach upsets? Yes No 21. Autism Spectrum Disorder? Yes No Yes No 30. Operations/serious injuries? Yes No 22. Emotional disability? Yes No 30. Operations/serious injuries? Yes No 23. Learning disability? Yes No 31. Other diseases/conditions? Yes Urinary tract infections? Yes No 24. Physical disability? Yes No Explanation of "Yes" answers (use another sheet of paper if needed): **RECORD OF IMMUNIZATIONS FOR GIRL MEMBERS** (HW.1.1-D)**	7. I	Bronchitis?	Yes N	o 19. Skin cond	itions?	Yes	No		Yes	No	
10. Constipation/diarrhea? Yes No 22. Emotional disability? Yes No 30. Operations/serious injuries? Yes 11. Bed wetting? Yes No 23. Learning disability? Yes No 31. Other diseases/conditions? Yes 12. Urinary tract infections? Yes No 24. Physical disability? Yes No Explanation of "Yes" answers (use another sheet of paper if needed): **ECCORD OF IMMUNIZATIONS FOR GIRL MEMBERS (HW.1.1-D)**	8. 1	Fainting/dizziness?	Yes N	•		Yes	No	b. If so, is her menstrual history	y normal?)	
11. Bed wetting? Yes No 23. Learning disability? Yes No 31. Other diseases/conditions? Yes 12. Urinary tract infections? Yes No 24. Physical disability? Yes No Explanation of "Yes" answers (use another sheet of paper if needed): RECORD OF IMMUNIZATIONS FOR GIRL MEMBERS (HW.1.1-D)		•	Yes N	o 21. Autism Sp	ectrum Disorder?	Yes	No		Yes	No	
12. Urinary tract infections? Yes No 24. Physical disability? Yes No Explanation of "Yes" answers (use another sheet of paper if needed): RECORD OF IMMUNIZATIONS FOR GIRL MEMBERS (HW.1.1-D)		·	Yes N		•	Yes	No		Yes	No	
Explanation of "Yes" answers (use another sheet of paper if needed):		•		_	<u>=</u> '			31. Other diseases/conditions?	Yes	No	
RECORD OF IMMUNIZATIONS FOR GIRL MEMBERS (HW.1.1 – D)		•		•	•	Yes	No				
RECORD OF IMMUNIZATIONS FOR GIRL MEMBERS (HW.1.1-D)											
r or traver outside or the office states, brease email info@asatan.ora for assistance with additional reduited vactinations.	RECORD C	F IMMUNIZATIONS FOR	GIRL MEMBE	RS (HW.1.1 – D)		ional reas	ired vacc	inations			
Kindergarten thru 6 th Grade 7 th Grade thru 12 th Grade Last Tetanus Immunization	i oi tiuve	-	• •	-		•					

RECORD OF IMMUNIZATIONS FOR GIRL MEMBERS (HW.1.1 - D)

Kindergarten thru 6th Grade		Grade	7 th Grade thru 12 th Grade Last Tetanus Immunizati		
DTaP/DT	HiB	Polio (IPV/OPV)	K thru 6 th Grade immunizations	(month) (year)	REQUIRED
MMR	Нер В	Нер А	Tdap Booster	[REQUIRED]	
Chicken Pox (Varicella)			Meningococcal		

Please check one of the following:

- The participant IS up-to-date on all immunizations listed above as required by the Utah Health Department and GSUSA.
- ☐ The participant IS NOT up-to-date on all immunizations listed above as required by the Utah Health Department and GSUSA.

- If a participant is any missing immunizations listed above, she cannot attend Girl Scout programs lasting 3 nights or more.
- The participant claims exemption to immunizations for medical, religious, or personal reasons (additional form is required from Utah Health Department).

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Signature of Parent/Guardian

IF ATTENDING A SUMMER RESIDENT CAMP PROGRAM, USE THE ONLINE HEALTH CARE RECORD SYSTEM –NOT THIS FORM. THIS FORM WILL BE USED FOR TROOP CAMPING, MINICAMPS, TRAVEL, ETC. QUESTIONS ABOUT THIS FORM? CONTACT INFO@GSUTAH.ORG

Participant Name:				
□ Vegetarian □ Vegan □ Gluten-free □ Lactose-free □ Other □	ALLERGIES (HW.1.1 – F and HW.4.1 – C) □ Drug □ Food □ Plants/Pollen/Insects □ Other Please explain severity of allergies (contact, ingestion, smell, etc.):			
PROGRAM PARTICIPATION (HW.1.1 – F and HW.4.1 – C)				
I understand the activities that are involved with the program that myself/camper is attendilist of activities that, due to health concerns, myself/camper will be exempt from:	ing. If clarification is needed, please contact info@gsutah.org . Below is a			
OVER-THE-COUNTER MEDICATIONS (HW.1.1 – B and HW.4.1 – D) Health services will provide over-the-counter medications listed below. If participant is a minor, please mark that your child has permission to take or use the follow as needed:	MEDICATIONS BROUGHT TO CAMP (HW.1.1-B and HW.4.1-D) All medications brought to Girl Scout programs, including prescription, over-the-counter, herbal, and so forth, must be turned in with the Medication Log form during check-in.			
□ Tylenol/Acetaminophen □ Tums/antacid □ Cough drops □ Sudafed/decongestant □ Advil/Ibuprofen □ Robitussin/expectorant □ Benadryl/antihistamine □ Calamine lotion	All medications must be in the original containers. All prescription medications must be prescribed for the individual taking the medication.			
PERMISSION TO TREAT (HW.2.1 – AB and HW.4.1 – E)				
 I give permission for the staff/volunteers to provide, seek, and consent to routine health the-counter medications agreed to on this form, and emergency treatment of said particional authorize staff/volunteers to transport said participant to off-property health care faciliii. For minors, in the event the parent/guardian cannot be reached during an emergency, I glisted on this form. In the event no one can be reached, I give permission for emergency limited to x-rays, routine tests and treatment, and/or hospitalization. PLEASE SIGN Signature of Parent/Guardian Database Signature of Parent/Guardian	ipant. ties if deemed necessary by staff. give permission for staff/volunteers to contact the emergency contacts medical providers to secure and administer treatment including, but not			
Refusal to sign this section requires you to contact the Girl Scouts of Utah for a refusal-to-tree	at form prior to the program date (<u>info@qsutah.orq</u>). (HW.2.1 – AB and HW.4.1 – E)			
HEALTH INFORMATION PRIVACY STATEMENT The Health History Form is for health care concerns at the specified event only. All records this information for the benefit of the participant. All medical records will be held in limited necessary information may be shared with event staff volunteers in order to provide adequation of the information will it is destroyed. All forms/records with noted treatment vaccess to the information will be limited, but copies may be requested from the event spon procedures for handling the health form information and I agree to the release of any record health history is complete & accurate. I give permission to engage in all prescribed activitions.	d access by the health care supervisor of the specific event. Minimal ate participant safety and health care. The health form will be retained by will be retained for seven years past the age of maturity of the participant. sor, by the participant, or their legal representative. I have read the above ds necessary for treatment, referral, billing, or insurance purposes. This			
PLEASE SIGN Signature of Parent/Guardian Dar	te			
DESIGNATED DRIVER RELEASE To ensure the safety of minors, girls will only be released to those listed below.				
Be taken to program by: Name Relation	nship to minor Phone			
Be taken home by: Name Relation	nship to minor Phone			
PERMISSION STATEMENT I give permission for all participants listed above to: • Attend the Girl Scout program listed above. • Have photographs, video, audiotape, and artist renditions to be taken of them release said images for the promotion and publicity of Girl Scouting. • HIGH RISK ACTIVITIES: I recognize that some Girl Scout activities such as horsel the waterfront are high-risk activities and can be dangerous. I will be responsib I/she will only participate if I/she is in good physical condition. • ADVENTURE AND LEADERSHIP PROGRAMS: I understand that I/my camper ma property. Overnight campouts are part of some programs. Girl Scouts in leaders programs. Girl Scouts in high adventure programs may also be transported to p Girl Scout to and from these activities.	pack riding, climbing, rappelling, biking, rafting, ropes course, archery, and le for ensuring that I/my Girl Scout(s) brings the required equipment and ay participate in hikes and adventure activities off of Girl Scout owned ship programs may be transported to various program sites during their			
Signature of Self or Parent/Guardian of Minors	Date			