GIRL SCOUTS OF NEW JERSEY HEART

Girl Health History Record

Girl Scouts. 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)

□ 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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□ Insect Stings _____ □ Other (specify)_____

(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
(973)746-8200

North Branch Service Center
(908)72501226

Westfield Service Center
(908)232-3236

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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) _____

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Measles	_____	_____
Mumps	_____	_____
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Oral Polio	_____	_____
Hbpv	_____	_____

Tuberculin Test (most recent) Result _____ Other (specify)_____

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Name _____ Day/Evening Telephone _____ Relationship _____

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