Girl Scouts of Southeastern Michigan

Girl Health Information Form

Purpose of this Form

This form contains information regarding allergies and dispensing medication to girl members and is to assist in providing appropriate care. This form should be kept in the Troop Leader/Advisor's troop records and should not be returned to GSSEM.

Family Information

Name: _____ Date of Birth: _____

Address: _____

Parent/Guardian 1 Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Guardian 2 Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physician Information

Name of Family Physician: _____ Phone Number: _____

Insurance Carrier: _____ Policy/Group Number: _____

My child needs the following accommodations for physical, developmental, or mental health issues:

_____

_____

Allergy Information

My child is allergic to the following foods: _____

_____

My child is allergic to the following medications: _____

_____

Signs to look for in case of an allergic reaction: _____

_____

If my child has an allergic reaction, leaders should do the following: _____

_____

_____

In Case of Emergency
In case of emergency, if the parent/guardian cannot be reached, the Leader will notify the following individual(s), who will notify the parent/guardian:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Permission to Dispense Medication
Only to be used by leaders when medication needs to be dispensed to a minor during a field trip or troop meeting.

PLEASE NOTE: All prescribed and over-the-counter medications must be in their original containers with the original dosage or prescribed directions on the container. Pills and/or vitamins will not be allowed in a baggie or pre-counted in a pill box. Include things such as allergy and menstrual cramp relief medications. If a prescription does not have your child's name as the designated patient, the medication will not be administered. Over-the-counter or prescription medications will be collected by the adult chaperone/First Aider who will be responsible for dispensing the medication. The only exceptions will be EpiPens and inhalers, which should be listed below and carried by the child. Medication will not be dispensed without a parent/guardian signature.

My child takes the medications listed below on a regular basis:
(Include such things as allergy and menstrual cramp relief medications. If a prescription does not have your child's name as the designated patient, we cannot administer the medication)

Medication Name Prescription/Non-Pres. Dosage Amount & Time Possible Side Effects

A: _____

B: _____

C: _____

My child has my permission to take the over-the-counter medications indicated below as deemed necessary by the event First Aider/health supervisor:

Acetaminophen (i.e. Tylenol, Anacin II)	☐ Yes ☐ No	Ibuprofen (i.e. Advil, Motrin)	☐ Yes ☐ No
Throat Lozenges	☐ Yes ☐ No	Antibiotic Ointment	☐ Yes ☐ No
Eye Rinse	☐ Yes ☐ No	Caladryl/Benedryl	☐ Yes ☐ No
Tums	☐ Yes ☐ No	Hydrocortisone Cream	☐ Yes ☐ No
Other:	☐ Yes ☐ No	Other:	☐ Yes ☐ No

Parent Approval
By signing below, I authorize that all of the information included in this form is correct.

Signature of Parent/Guardian: _____

Print Name: _____ Date: _____