girl scouts of southwest indiana

Annual Troop Health Form

October 1, 2024 – September 30, 2025

TROOP VOLUNTEER:
This form MUST be on hand at all approved Girl Scout meetings/activities/events and **must be updated as needed or annually.**
Please keep the form and information safe and confidential.

GIRL INFORMATION

Troop/Group #_____ Service Unit/Registration Area_____

Girl's Name_____ Date of Birth____/____/____ Age_____

School_____ Grade_____ Level: (Choose 1): D B J C S A

Address_____

Mother/Guardian's Name (printed)_____ Email_____

Mobile _____ Work_____ Home_____

Address_____
(If different from Girl's Address)

Father/Guardian's Name (printed)_____ Email_____

Mobile _____ Work_____ Home_____

Address_____
(If different from Girl's Address)

Emergency contact person if parents/guardians cannot be reached:

Name_____ Relationship_____ Mobile_____

RELEASE INFORMATION

Custody Type: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other_____

The following person(s) may pick up my child: ☐ Mother ☐ Father ☐ Other (list below)

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

The following individual(s) may NOT pick up my child: _____

MEDICAL INFORMATION

Date of last health exam _____ Family Physician _____ Phone _____

Family medical/hospital insurance carrier _____ Policy/Group# _____

Current medications _____ Possible side effects _____

Restrictions to participating in activities _____

Any special needs/adaptations or additional remarks _____

IMMUNIZATIONS

Date of basic tetanus immunization _____ Date of last booster _____

Check type: ☐ DPT (diphtheria, pertussis, tetanus) ☐ DT (diphtheria, tetanus)

ALLERGIES (Check all that apply)

☐ Animals ☐ Pollen ☐ Medicine/Drugs ☐ Insect Bites/Stings ☐ Hay Fever

☐ Food ☐ Plants ☐ Other

List specific allergies to checked boxes above_____

CHRONIC OR RECURRING ILLNESSES/CONDITIONS (Check all that apply)

☐ Asthma ☐ Ear Infection ☐ Kidney Disease ☐ Seizures ☐ Diabetes

☐ Heart Defect Disease ☐ Hypertension ☐ Musculoskeletal Disorders ☐ Mental Health ☐ Other

Specify any checked boxes above_____

OTHER CONDITIONS (Check all that apply)

☐ Motion Sickness ☐ Nosebleeds ☐ Fainting ☐ Hearing Impairment ☐ Learning Disability

☐ Special Dietary Regiment ☐ Glasses/Contact Lenses ☐ Other

Specify any checked boxes above_____

Is there any additional information about your daughter that we should know to better serve her?

(i.e. medical/behavioral, family situation, concerns, etc.)

_____

MEDICATION ADMINISTRATION & EMERGENCY TREATMENT RELEASE

Indiana State law requires the observation of certain regulations when administering medication to children and adolescents. The following procedures **must** be followed:

Over the counter and prescription medication requires written permission from parent or guardian, stating the name of medication, amount of medication, the hours for administration, and the period of time medication is to be continued. It must be sent in the original container labeled with the girl's name. Prescription medication labels must meet the requirement for physician(s) written order.

Some girls may need to carry and administer their own medications, such as bronchial inhalers, EpiPens or diabetes medication. You must have documentation from the girl's parent or guardian that it is acceptable for the girl to self-administer these medications.

The parent/guardian shall accept the legal responsibility for the safe arrival of his/her child(s) medication to and from the activity. The Certified First Aider may return unused medication with the adult taking the child home.

Medication	Prescription Number	Doctor Prescribing	Dosage	Time to Administer	Possible Reactions

I hereby authorize Girl Scouts of Southwest Indiana (GSSI), Troop/Group Lead Volunteer, and/or Troop/Group event first aider to administer medication to my child, as stated above.

I understand that in case of any medical emergency every effort will be made to contact me. If this is impossible, I authorize GSSI, Lead Volunteer, and/or event first aider to contact my child's physician and to secure emergency medical treatment.

Signature of Parent/Guardian _____Date _____

Printed Name of Parent/Guardian _____