PARTICIPANT HEALTH HISTORY RECORD

(to be completed & signed by the parent/guardian of the participant on the reverse)
Bring this 2-page form with you to each activity site.

Full Name of Participant: ______________________________

Troop #:__________ Date of Birth:__________ Social Security # (optional): ______________

Address:______________________________
City State Zip

Name of Family Physician: ______________________________

Phone number of Physician: (_____)____________________ Ext. ______________

Family Medical/Hospital Insurance Carrier: ______________________________

Policy or Group Number: ______________________________

GENERAL

(Check all of the following that apply to the participant.)

❏ Ear Infection ❏ Bleeding/Clotting Disorders ❏ Hypertension ❏ Asthma ❏ Heart Defect/Disease
❏ Musculoskeletal Disorder ❏ Seizures ❏ Diabetes ❏ Other (specify) ______________

Date of last health examination: ______________________________

Were any complicating medical problems noted in last health examination ? (If so, describe.)

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ALLERGIES

(Check all of the following that apply to participant and specify nature of allergic reaction as well as specific allergy.)

❏ Animals ❏ Medicine/Drugs ❏ Hay Fever ❏ Insect Stings ❏ Pollen ❏ Plants ❏ Food
❏ Other Please specify any allergy that you have checked. ______________________

OTHER HEALTH CONDITIONS

(check all of the following that apply):

❏ Constipation ❏ Menstrual Cramps ❏ Motion Sickness ❏ Nosebleeds ❏ Emotional Disturbances
❏ Fainting ❏ Hearing Impairment ❏ Sickle Cell Trait or Disease ❏ Special Dietary Disease
❏ Wears Glasses or Contacts ❏ Other (specify): ______________________

Please explain any items checked above. Indicate any information useful to the adult in charge in relation to any of these health conditions. Indicate any activities to be encouraged or restricted.

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IMMUNIZATION HISTORY:

Immunization	Year Primary Series Completed	Year of Last Booster
D.P.T.		
TD (tetanus/diphtheria)		
Measles		
Mumps		
Rubella (German Measles)		
Oral Polio		
Hib		
Date of Tuberculin Test (most recent): Result:		
Other:		

GIRL SCOUTS OF MIDDLE TENNESSEE
PROGRAM PERMISSION SLIP

Full Name of Participant: ___________________________________ Troop # ________________________

PERMISSION TO PARTICIPATE IN ADVENTURE/CAMP PROGRAMS
I give permission for my child to participate in any of the following adventure programs / camp programs offered by the Girl Scouts of Middle Tennessee: high ropes, team adventure, obstacle course, wagon ride (with or without cookout), rappelling, climbing, backpacking, canoeing, tree climbing, archery, kayaking, and sailing. I understand that if I have any questions or concerns about these programs (or the risks involved in these programs), I can contact the Girl Scouts of Middle Tennessee (615-383-0490 or 800-395-5318) for more information.

Parent/Guardian Signature__________________________________ Date__________________________

EQUESTRIAN (HORSE) PERMISSION AND AGREEMENT
WARNING: Under Tennessee Law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Tennessee Code Annotated,Title 44, Chapter 794.

I give permission for my child to participate in an equine activity at Camp Sycamore Hills and agree to assume the associated risks.

Parent/Guardian Signature__________________________________ Date__________________________

PHOTO RELEASE
I give consent for my child to be videotaped, photographed or audio taped for use by the Girl Scouts of Middle Tennessee. Furthermore, I consent that such photographs, films and recordings shall be their property, and they shall have the right to duplicate, reproduce, and make other uses of such photographs, films and recordings as they desire free and clear of any claim whatsoever on my part.

Parent/Guardian Signature__________________________________ Date__________________________

PERMISSION TO TREAT
I hereby give permission to the medical personnel selected by the Girl Scout staff to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child participant. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp staff to secure and administer treatment, including hospitalization, for the child participant named on this form. I also give permission for first aid certified program staff to administer first aid for minor medical needs (such as cuts and scrapes, sprains, stings and bites, etc.). The Girl Scouts and/or hospital may photocopy this completed form.

Parent/Guardian Signature__________________________________ Date__________________________
Print Parent/Guardian Name: ____
If there are any exceptions, please describe: ____
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EMERGENCY CONTACT INFORMATION (Please Print)

1. Parent/Guardian Name ______________________________ Phone (Day/Cell) __________________
2. Parent/Guardian Name ______________________________ Phone (Day/Cell) __________________
3. Alternate Contact ___________________________________ Phone (Day/Cell) __________________

 Revised May 2008