General Permission and Health History Form

girl scouts arizona cactus-pine

Complete for youth or adult participants

Please complete all applicable sections. Update this form whenever the participant's health information, emergency contacts, insurance, medications, or permissions change.

PARTICIPANT INFORMATION

☐ Youth participant ☐ Adult participant

Full Legal Name	Birth Date (mm/dd/yyyy)
Preferred Name	Troop/Group #
Primary Phone	Alternate Phone
Address	City, State & Zip Code

PARENT/GUARDIAN INFORMATION - REQUIRED FOR YOUTH PARTICIPANTS

Parent/Guardian (1) Name	Relationship	Primary Phone
Email	Alternate Phone	
Parent/Guardian (2) Name	Relationship	Primary Phone
Email	Alternate Phone	

EMERGENCY CONTACTS

If a parent/guardian cannot be reached, the primary emergency contact is authorized to act on the parent/guardian's behalf. For a youth participant, list at least one adult guardian among the emergency contacts.

Primary Emergency Contact Name	Relationship	Primary Phone
Address	City, State & Zip Code	Alternate Phone
Secondary Emergency Contact Name	Relationship	Primary Phone
Address	City, State & Zip Code	Alternate Phone

Health History

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Participant Name: _____

HEALTH AND MEDICAL INFORMATION

Do you have any health or medical issues that should be communicated in case of an emergency?

☐ Yes ☐ No

Describe health conditions, severe allergies, disabilities, dietary needs, assistive devices, or other concerns. Include symptoms, treatment, and date of last occurrence when applicable.

Condition or concern / symptoms / treatment / date of last occurrence:

Allergies: Check all that apply and explain below.

☐ Medicine/drugs ☐ Foods ☐ Insect stings ☐ Environmental/hay fever ☐ Other

Allergy details, reaction, and response plan:

Do you have restrictions concerning physical activities? ☐ Yes ☐ No

If yes, explain:

Is there a specific dietary regimen to follow? ☐ Yes ☐ No

If yes, explain (for example: vegan, gluten-free, halal, diabetic, kosher, dairy-free)

INSURANCE INFORMATION

Insurance Carrier	Member/ID Number	Group Number
Member Services Phone	Policyholder Name	

PHYSICIAN INFORMATION

Primary Care Physician Name	Physician Phone

EMERGENCY CARE AUTHORIZATION

☐ In the event of illness, injury, or emergency, Girl Scouts–Arizona Cactus-Pine Council, Inc. may arrange appropriate emergency medical or surgical care and/or hospitalization as needed. Reasonable efforts will be made to contact me or the emergency contacts listed on this form. If contact cannot be made, I authorize Girl Scouts–Arizona Cactus-Pine Council, Inc. to seek treatment for my child from a licensed medical professional.

Medication Information

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Participant Name: _____

MEDICATION ADMINISTRATION INFORMATION

A qualified health care professional who is licensed to distribute medication, or a designated volunteer, may administer medication to participants. Arrangements between the parent/caregiver and the designated volunteer must include the following:

1. Prescription and over-the-counter medications must be provided in their original containers.

2. Prescription medications must be prescribed to the individual taking them.

3. All medications must be reviewed with the designated volunteer or first aider/health care professional. Non-emergency medications will be held by the designated volunteer or first aider/health care professional.

4. Emergency medications for life-threatening conditions may need to be carried and secured by the participant and communicated to the troop leader or first aider. Examples include epinephrine injectors, asthma inhalers, and supplies for diabetic or seizure emergencies. Non-emergency medication must be secured out of reach of other participants.

PRESCRIPTION AND EMERGENCY MEDICATION

List all prescription medications the participant is required to take, including self-administered emergency medication.
Attach additional pages as needed.

Medication 1	Dosage / amount / time of day
Medication 2	Dosage / amount / time of day
Medication 3	Dosage / amount / time of day

☐ **Permission to self-administer emergency medication**
I confirm that the participant has the knowledge and skills to safely carry and self-administer the indicated emergency medication as medically necessary during Girl Scout activities. The troop leader or first aider will be notified if the medication is used.

OVER-THE-COUNTER MEDICATION

Participant is allowed to take over-the-counter medication: ☐ Yes ☐ No

Check any over-the-counter medication the participant is **NOT permitted** to take.

- ☐ Ibuprofen
- ☐ Decongestant
- ☐ Anti-diarrheal
- ☐ Artificial tears
- ☐ Menstrual cramp relief
- ☐ Acetaminophen
- ☐ Cough drops
- ☐ Expectorant
- ☐ Anti-fungal cream
- ☐ Antihistamine
- ☐ Motion sickness medicine
- ☐ Aloe vera
- ☐ Triple-antibiotic ointment
- ☐ Antacid
- ☐ Calamine lotion

Other medication not permitted / special instructions:

ADDITIONAL INSTRUCTIONS

Medication storage, accessibility, communication, or other instructions:

General Permission and Signatures

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Participant Name: _____

GENERAL PERMISSION

I am the participant, or the parent/guardian having legal custody of the youth participant named on this form, and I have authority to give this permission. The participant has permission to participate in Girl Scout troop meetings and activities less than four hours in length that are conducted or sponsored by the troop or group listed on this form, or by Girl Scouts–Arizona Cactus-Pine Council, Inc., except as noted on this form.

PHOTO AND MEDIA PERMISSION

During Girl Scout activities, the participant may be photographed, videotaped, or electronically imaged. Images may be used in promotional materials, news releases, and other published formats by the local Girl Scout council or Girl Scouts of the USA. The images will be the property of the local Girl Scout council or Girl Scouts of the USA.

☐ **I wish to opt out of photo and media use at this time.**

TERMS AND CONDITIONS

This health history is correct and accurately reflects the participant's health status. The participant has permission to participate in activities except as noted by me or an examining physician. I authorize medical, surgical, diagnostic, and hospital care or procedures that may be performed or prescribed by a licensed physician or hospital when efforts to contact the emergency contacts are unsuccessful and the care is deemed immediately necessary or advisable to safeguard the participant's health. I waive my right of informed consent to such treatment and accept responsibility for charges that occur. Girl Scout insurance is secondary to the participant's primary insurance.

I understand that information on this form may be shared with staff and volunteers on a need-to-know basis for participant safety. I give permission to copy this form. Girl Scouts–Arizona Cactus-Pine Council, Inc. may obtain relevant health information from providers who treat the participant, and those providers may discuss the participant's health status with authorized staff. By signing, I affirm that this form is correct and complete to the best of my knowledge and that I have read, understood, and agree to these terms and conditions.

SIGNATURES

Parent/Guardian Name (Print)	Date
Parent/Guardian Signature	Primary Phone
Adult Participant Name (Print)	Date
Adult Participant Signature	

ANNUAL REVIEW

Review this form at least annually and whenever information changes. Signing below confirms that the information remains accurate or has been updated.

Review Signature	Review Date
Second Review Signature	Review Phone