

# HEALTH HISTORY - Girl

## HISTORIA DE SALUD - Niña

**INSTRUCTIONS:** Parent should complete information, Health History and Treatment Authorization sections.

**DIRECCIONES:** Los Padres de familia deben completar las secciones de información, Historia de Salud y Autorización para Tratamiento Médico.

**Please Print or Type / Favor de Imprimir**

### INFORMATION

Name/Nombre \_\_\_\_\_ Birth Date/Fecha de Nacimiento \_\_\_\_\_

Address/Dirección \_\_\_\_\_

City/Ciudad \_\_\_\_\_ Zip/Código Postal \_\_\_\_\_

Parent/Guardian // Padre/Guardián \_\_\_\_\_

Phone/Teléfono (H)(\_\_\_\_\_) \_\_\_\_\_ (B)(\_\_\_\_\_) \_\_\_\_\_

If Parent/Guardian cannot be contacted, please notify:// Si Un Padre/Guardián no se encuentran, notifique a:

Name/Nombre \_\_\_\_\_

Phone/Teléfono (H)(\_\_\_\_\_) \_\_\_\_\_ (B)(\_\_\_\_\_) \_\_\_\_\_

Name/Nombre \_\_\_\_\_

Phone/Teléfono (H)(\_\_\_\_\_) \_\_\_\_\_ (B)(\_\_\_\_\_) \_\_\_\_\_

Physician/Médico \_\_\_\_\_ Phone/Teléfono (\_\_\_\_\_) \_\_\_\_\_

Medical/Hospital Insurance Carrier  
Nombre de la Aseguradora Médica \_\_\_\_\_

Policy/Group Number  
Número de Póliza \_\_\_\_\_

### HEALTH HISTORY

Allergies: Check all that apply/ Alergias: Marque a los que son aplicable:

- |  |   |
|--|---|
| <input type="checkbox"/> Animals/Animales _____                                | <input type="checkbox"/> Plants/Plantas _____                   |
| <input type="checkbox"/> Food/Comidas _____                                    | <input type="checkbox"/> Pollen/Polen _____                     |
| <input type="checkbox"/> Insect bites/stings//Piquete de insecto/aguijón _____ | <input type="checkbox"/> Medicines/Drugs//Medicina/Drogas _____ |
| <input type="checkbox"/> Hayfever/Fiebre del Heno _____                        | <input type="checkbox"/> Other/Otra _____                       |

**Immunizations:** Full dates (day/month/year) are required by the Texas Health Department // Vacunas: Fecha de Últimas Vacunas

You may attached an immunization record from your doctor.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DPT(Diphtheria/Pertussis/Tetanus)					
TD (Tetanus Booster)(Diphtheria/Tétanos)					
Measles/Sarampión, Mumps/Paperas, Rubella/Rubela					
Oral Polio/Polio					
Hepatitis B					
Chicken Pox (Varicella)					
Haemophilus Influenzae Type B (HIB)					
Pneumococcal vaccine (PVC/PPV)					
Hepatitis A					
Tuberculin test (Result)/Examen de tuberculosis (resultado)					

Has begun menstruation?// ¿Ha comenzado su periodo?  Yes/Si  No Is informed about it?// ¿Esta informada?  Yes/Si  No

Current medication: specify \_\_\_\_\_ Needed during camp?  Yes  No

Medicina que toma actualmente: \_\_\_\_\_ ¿Lo necesita durante el campamento?  Si  No

Check if child wears:  Contact lenses  Glasses  Dental appliance  Other \_\_\_\_\_

Marque si niña(o) usa:  Pupilentes  Anteojos  Auxilio dental  Otra \_\_\_\_\_

**May be given: // Se puede dar:**

<b>Tylenol</b>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No	<b>Antiseptic Ointment</b>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
<b>Ibuprofin</b>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No	<b>Calamine Lotion</b>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
<b>Benadryl</b>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No	<b>Insect Repellent</b>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No

Chronic/Recurring Conditions: Check all that apply// Condiciones Crónicas: Marque los que aplican:

<input type="checkbox"/> Asthma/Respiratory Problems//Asma/Problemas de Respiratorio	<input type="checkbox"/> Epilepsy/Epilepsia
<input type="checkbox"/> Kidney Disease/Enfermedad de Riñon	<input type="checkbox"/> Headaches/Dolores de Cabeza
<input type="checkbox"/> Heart Disease/Enfermedad de Corazón	<input type="checkbox"/> Fainting/Desmayo
<input type="checkbox"/> Diabetes/Diabetis	<input type="checkbox"/> Nosebleed/Hemorragia Nasal
<input type="checkbox"/> Ear Infection/Infecciones del Oído	<input type="checkbox"/> Bleeding/Clotting Disorders/Problemas de Sangre
<input type="checkbox"/> Special Dietary Regimen/Dieta Especial	<input type="checkbox"/> Hypertension/Hipertensión
<input type="checkbox"/> Seizures/Ataques Apopléticos	<input type="checkbox"/> Constipation/Estreñimiento
<input type="checkbox"/> Emotional Disturbances/Problemas Emocionales	<input type="checkbox"/> Hearing Impairment/Dificultades en Oír (Sordo)
<input type="checkbox"/> Sickle Cell Trait or Disease/Tendencia del Sickle Cell Anemia	<input type="checkbox"/> Musculoskeletal Disorders/Desarreglo del Sistema
<input type="checkbox"/> Other/Otra _____	<input type="checkbox"/> Musculoescelatal

Please explain any items that are checked. Indicate any information useful to the adult in charge about any of these health conditions. Also indicate any activities to be encouraged/restricted. \_\_\_\_\_

Date last examination/Fecha de último examen médico \_\_\_\_\_

Since last health exam, has participant had:		a serious injury/illness requiring medical attention?	<input type="checkbox"/> yes/si	<input type="checkbox"/> no/no
the care of a physician or psychologist?	<input type="checkbox"/> yes/si	recent exposure to a contagious disease	<input type="checkbox"/> yes/si	<input type="checkbox"/> no/no
restrictions in physical activities?	<input type="checkbox"/> yes/si	any prescribed/ over the counter medications?	<input type="checkbox"/> yes/si	<input type="checkbox"/> no/no

Please explain any "yes" to the above, include dates: \_\_\_\_\_

Are activities restricted?// ¿Esta restringida su actividad física? \_\_\_\_\_ No/No \_\_\_\_\_ Yes/Si

If Yes, explain/explicue \_\_\_\_\_

## TREATMENT AUTHORIZATION

**Parent/Guardian Statement:** This health history is complete and accurate. I know of no reason(s), other than indicated on this form, why my daughter/child should not participate in camp activities except as noted. I authorize the Girl Scout adult in charge to consent to medical treatment when either I or my assignee cannot be contacted. I understand that every effort will be made to contact me before such action. I assume financial responsibility for emergency care if such care is not covered by GSUSA Activity Accident Insurance.

**Declaración de Padre/Guardián:** Yo autorizo a la persona adulta encargada de las Girl Scouts que consiga tratamiento médico para mi hija cuando yo o la persona que he asignado, no pueda ser encontrado. Yo asumo cualquier responsabilidad financiera de tratamiento de emergencia, si tal no se cubre por la aseguransa de Girl Scouts.

\_\_\_\_\_  
Signature of Parent/Guardian// Firma de Padre/Guardián

\_\_\_\_\_  
Date/Fecha