

GIRL/YOUTH MEMBER *(Must be completed by parent/guardian annually and update as needed)*

ADULT MEMBER *(Only needs to be completed for overnight or high risk activities)*

Please Print Clearly

CONTACT INFORMATION	Troop #: _____ or Individual <input type="checkbox"/>	Service Unit: _____		
	First Name: _____	Middle Name: _____	Last Name: _____	
	Mailing Address: _____		Apt. #: _____	PO Box: _____
	City: _____	State: _____	Zip Code: _____	Phone: _____
	Cell: _____	E-mail: _____		
	Parent/Guardian Name and address <i>(If different from child's): (Complete for girl/youth only)</i> 1. _____		Phone: _____ Cell: _____	
	Parent/Guardian Name and address <i>(If different from child's): (Complete for girl/youth only)</i> 2. _____		Phone: _____ Cell: _____	
	Custodial Care Information: <input type="checkbox"/> Both Parents <input type="checkbox"/> One Parent (specify): _____ <input type="checkbox"/> Other: _____			

HEALTH INFORMATION	Name of Family Physician: _____		Phone: _____
	Family Medical/Hospital Insurance Carrier: _____		Policy or Group No: _____
	Family Dental Insurance Carrier: _____		Policy or Group No: _____
	Health Information: Age: _____	Date of Birth: _____	<input type="checkbox"/> Immunizations are up to date in accordance with California Health and Safety Code 120335 (required to attend California public schools) If no, please explain
	Date of last Tetanus shot: _____		
	Date of last health examination: _____		Were there any medical concerns at the time? _____
	Does participant have any physical, mental or psychological conditions requiring medication, treatment, or other special restrictions or considerations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain		
	Does participant take any prescribed medications or over-the-counter drugs on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list medication here and for girl/youth complete Girl Medication Permission Form		
	Is participant restricted or limited from participating in any physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		
	Are there any other ongoing or current medical conditions that could impact participation? If yes, please explain or write none.		
Participant has the following health conditions/allergies/dietary restrictions (food and medications): <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____ <input type="checkbox"/> Allergies (specify): _____			
Emergency Contact (non-parent): _____			
Relationship: _____	Phone: _____	Cell: _____	

AUTHORIZATION	GUARDIAN/ADULT AUTHORIZATION This health form is complete and accurate. I authorize Girl Scouts of Northern California to collect, use, and share the medical information provided on this form as necessary for the health and safety of my child during Girl Scout Activities. This may include sharing with trained staff, volunteers, or healthcare professionals in case of emergency or as needed for medical treatment. This authorization will expire at the end of the membership year or earlier if revoked in writing.
	Signature of guardian/adult: _____ Date: _____
AUTHORIZATION	ADULT MEMBER AUTHORIZATION This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.
	Signature of adult member: _____ Date: _____

This form will be stored securely by the troop/group leader and will accompany the adult in charge to all meetings and activities. All health information will be kept confidential and only be used by authorized personnel for the purpose of ensuring the safety and well being of the participant.