Health History Information & Permission Form for Overnights

Troops/groups/service units engaging in overnights lasting 1-2 nights must have a Health History & Permission Form for Overnights for every girl. This form is to be completed by the Parent/Guardian and submitted to the troop's First Aider. First aiders will review each form, consult with the parent/guardian for clarity, and carry each form in a sealed envelope with the first aid kit. In the event of an emergency, the form will be given to the appropriate health provider. Note: This form contains sensitive and private information, and will be kept confidential.

Girl Scout's Name:		Age:		Date of Birth:	
Name of Caregiver:		Caregiver Phone:			
Girl's Full Address (City, State, Zip):		Home:			
		Cell:			
		Work:			
In an Emergency, if caregivers cannot be reached, notify:		Emergency Contact Telephone Number(s):			
		Home:			
		Cell:			
Relationship to Girl Scout:		Work:			

Health History (Please Print)

Health Insurance Provider:		Policy#:		Group:		
Please provide and information about the Girl Scout's health history that will ensure their safety in this overnight (e.g., uses an inhaler; allergic to bees; has a seizure disorder, etc). Please be specific:						
Please list any allergies (food, medicine, environmental):						
Does the Girl Scout have any dietary restrictions?	No	Yes	Explain:			
Completed by Troop Leader: List any activities the Girl Scouts will engage in:						
Completed by Caregiver: List any activities the Girl Scout should be exempt from:						
Date of last tetanus shot: (month/year)						

Permission:

In signing this form, I hereby give permission for the above mentioned girl to attend the overnight at

_____, on _____

Name and Location of Overnight — Date and Time of Overnight

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me. I also hereby give permission to authorize Girl Scouts of Eastern Massachusetts and my (our) child's/ward's troop/group volunteer and/or First Aider to consent to any medical care and treatment that is recommended by a licensed healthcare provider to whom the child/ward is presented for treatment. I understand that in the event of an emergency, every effort will be made to contact me. However, whether or not I can be contacted, I hereby give permission to the Girl Scouts of Eastern Massachusetts, the troop/group volunteer and/or the First Aider to arrange to have my child or ward transported to a hospital or other medical treatment facility, and to arrange to have my child provided with emergency examination and treatment and to hospitalize, and to order injection, blood transfusion and/or anesthesia and/or surgery for my child or ward as named above. In addition, I authorize the Girl Scouts of Eastern Massachusetts, the troop/group volunteer or the First Aider to provide First Aid to my child or ward as they may deem necessary in their discretion and to administer the medications as listed and directed on the following page.

I hereby release the above-referenced Girl Scouts of Eastern Massachusetts and their employees, agents, assigns, and successors from all demands, actions, causes of action, suits, damages, claims and liabilities, of every name and nature both in law and in equity, in any way related to my child or ward's participation in the overnight program including, but not limited to, those related to emergency medical care, first aid, or medications authorized above.

Signature of Caregiver: _____ **Date** ____/ _____/ ____

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Permission to Administer Medication

I hereby give permission for the Group First Aider _____ to
(first aider's name)
administer to _____ medications listed on this and any
(child's name)
attached pages in accordance with Massachusetts State Regulation 105 CMR 430.160. Standards for Recreational Camps for Children:

Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for girls shall be kept in the original container containing the original label, which include the directions for use. Please mark all medications with child's name. Medications sent in improperly will not be given.

When no longer needed, medications will be returned to a parent/guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

The Group First Aider has permission to administer the following over the counter medications to my child as deemed necessary (please check all that apply). Note: Aspirin will not be given to any child.

	Tylenol (Acetaminophen)
	Motrin (Ibuprofen)
	Antihistamine (Benadryl tablet, liquid)
	Anti-Itch Antihistamine (Benadryl cream)
	Allergy Relief (Loratadine - Claritin)
	Motion Sickness (Dramamine, Bonine)

	Antacids (Tums, Mylanta)
	Cough Drops
	Cough Syrup (Robitussin)
	Anti-Diarrheal (Imodium, Kaopectate)
	Insect Repellant (with or without DEET)
	Sun Screen

For prescription Epi-pen® or inhaler: My child **is / is not** capable of self-medicating; my child is allowed to carry these devices with them at all times and to use them if so required. Any Girl Scout coming to Encampment with a prescription Epipen® or inhaler, must bring two of either, one for the First Aider and one to keep with her.

THE FOLLOWING MEDICATION IS/ARE TO BE GIVEN TO _____ DURING OVERNIGHT.
(child's name)

If you are sending more than five medications, either prescribed or over the counter, please copy this page before listing. Please complete all information for each medication sent.

	Name of Medication	Quantity Sent	Dosage	Frequency	Special Instructions (i.e. given with food)	Storage Requirements
1						
2						
3						
4						

Signature of Caregiver: _____ **Date** ____/ _____/ _____

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