



**Girl Scouts of Greater Chicago
and Northwest Indiana**
Vernon Hills Regional Service Center

Girl Health History and HIPAA Form

This form must be completed and signed by parents/guardians of girls. All Health History forms will be held in limited access by the trustee (leader/facilitator/staff) of the specific Girl Scout program. The absolute minimal necessary information may be shared with program staff/volunteers in order to provide adequate health care. The Health History and HIPAA Form will be retained by the Girl Scout program trustee until it is destroyed.

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Birth Date _____

Name of Family Physician _____

Physician's Phone _____ Date of Last Exam _____

Name of Insurance Company _____

Policy or Group No. _____

Major Health Conditions (check all that apply)

- | | | | |
|---|--|-----------------------------------|--|
| <input type="checkbox"/> Bleeding/Clotting Problems | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bone/Joint Problems |
| <input type="checkbox"/> Sickle Cell Trait or Disease | <input type="checkbox"/> Other (specify) _____ | | |

Allergies (check all that apply and specify nature of allergic reaction)

- | | | |
|--|--|--|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Medicines _____ |
| <input type="checkbox"/> Pollen _____ | <input type="checkbox"/> Food _____ | <input type="checkbox"/> Insect Stings _____ |
| <input type="checkbox"/> Plants _____ | <input type="checkbox"/> Other (specify) _____ | |

Other Health Conditions (check all that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Wears Glasses/Contact Lenses | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Special Dietary Needs _____ | <input type="checkbox"/> Other (specify) _____ | | |

Please explain any items that are checked. To the best of your knowledge, do this girl have any physical or emotional condition that might prevent her from participating in Girl Scout activities? No Yes (explain)

IMMUNIZATION HISTORY

Please check if immunizations / boosters are up-to-date

- DPT or DT&P (Diphtheria, Pertussis (whooping cough), Tetanus)
- TD or DT (Diphtheria & Tetanus)
- Measles
- Mumps
- Rubella (German Measles)
- Combined MMR (Measles, Mumps, Rubella)
- Hib (Haemophilus influenzae type b)
- Polio
- Hepatitis B (HB)
- Tuberculin Test: Result _____
- Other (e.g., Varicella – chicken pox) _____

Emergency Contact

Emergency Contact Name:

Relationship to Girl:

Emergency Contact Phone:

Emergency Contact Phone:

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I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except, as noted.

I do hereby authorize the treatment by a qualified and licensed medical doctor for my daughter in the event of a medical emergency which, in the opinion of the attending physician, may endanger her life, cause disfigurement, physical impairment, or undue discomfort if delayed. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment, but treatment will not be withheld if the undersigned cannot be reached.

Providing false or incomplete information is a serious matter that may result in liability for damages and/or fraud.

Signature of parent/guardian Date

Signature of parent/guardian Date

Signature of parent/guardian Date

Please update and sign this card annually. Initial and date any changes.

Consent for Release of Personal and Health Information

New compliance form for Health Insurance Portability Accountability Act (HIPAA)

I authorize the use or disclosure of personal and health (includes medical, dental, and pharmacy) information by Girl Scouts of Greater Chicago and Northwest Indiana, as described below:

Any and all personal and health information Girl Scouts of Greater Chicago and Northwest Indiana maintains (including mental health, HIV and/or substance abuse records – cross out any item you do not authorize to be released).

Note: This consent form allows personal and health information to be shared via a telephone call with the person being authorized.

This information may be disclosed to, and used by the following individuals or organizations, including any medical personnel listed on health history portion, or any medical personnel attending to me during a medical emergency.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Girl Scouts of Greater Chicago and Northwest Indiana.

I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will apply while I am a member of this council.

I understand that I do not have to sign this authorization and that Girl Scouts of Greater Chicago and Northwest Indiana may not condition treatment on whether I sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Member, Legal Representative, or Parent/Guardian if under 18 years of age:

Name: _____ Date: _____

If signed by Legal Representative or Guardian, relationship to member:

Relationship: _____

If signed by legal representative, please provide representative documentation as required by state law, i.e., Power of Attorney, Health Care Surrogate, Living Will, or Guardianship papers.
