



Girl Scouts.

# Girl Scouts—Totem Council

## MEDICAL STATEMENT AND CONSENT TO MEDICAL CARE AND TREATMENT

In order that your child may receive prompt and appropriate medical treatment when you cannot be reached to give your consent, please sign the Consent of Parent or Guardian, Parent Safety Agreement for Daughter, and complete the Medical Statement on the back of this form, and immediately return it to your daughter's Troop Leader. This record will be retained by the Troop Leader for one year. Additionally, throughout the year, there will be the need for you to complete individual permission slips for specific troop activities.

The care of your child is uppermost in our thoughts and your cooperation is appreciated.

Girls' Name: \_\_\_\_\_

Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

Zip: \_\_\_\_\_

### CONSENT OF PARENT OR GUARDIAN

I, \_\_\_\_\_, am the parent or guardian having legal custody of the child named above. I authorize all medical, surgical, diagnostic, and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital, when efforts to contact me are unsuccessful and when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please designate: Parent  Legal Guardian

Child's Physician: \_\_\_\_\_

Physician's telephone number: \_\_\_\_\_

Physician's address: \_\_\_\_\_

Name of custodial parent(s) or legal guardian: \_\_\_\_\_

Home, work or cell phone numbers: \_\_\_\_\_

Alternate person(s) to contact in emergency:

<u>Name:</u>	<u>Work Phone</u>	<u>Home phone</u>	<u>City</u>	<u>Relationship</u>
_____	_____	_____	_____	_____

### PARENT SAFETY AGREEMENT FOR DAUGHTER

In Girl Scouting the health and safety of your daughter is one of our most important concerns. For this reason, we ask that you answer the questions below and read the information that follows very carefully.

- Will your daughter be walking home from the troop meeting? Yes  No
- Will someone be driving her home from the troop meeting? Yes  No
- What is the name and phone number of the person who will drive her home? \_\_\_\_\_
- Will anyone else have your permission to drive or walk her home? Name & phone number: \_\_\_\_\_  
Is there anyone that is NOT permitted to pick up your child? Name: \_\_\_\_\_

**Please read the statement below and sign your name at the bottom**

I have read the information above and have answered the questions. I understand that if my daughter is to have a ride home, I am responsible for seeing that the person I named in questions 3 or 4 above is there by \_\_\_\_\_ p.m. to pick her up. ( I understand that neither the leader nor Girl Scouts—Totem Council is responsible for driving her home or walking with her after \_\_\_\_\_ p.m.)

Signature of Parent or Guardian \_\_\_\_\_

Today's Date \_\_\_\_\_

**CHILD'S MEDICAL STATEMENT**

Girl's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

**CHRONIC ILLNESSES: CHECK IF APPLICABLE**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Disease of Kidneys          | <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Eyesight Impairment         | <input type="checkbox"/> Pneumatic Fever               | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Hearing Impairment          | <input type="checkbox"/> Abnormal Blood Pressure       | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Speech Impairment           | <input type="checkbox"/> Mental or Emotional Disorders | <input type="checkbox"/> Hernia               |
| <input type="checkbox"/> Disorders of Nervous System | <input type="checkbox"/> Ear Infection                 | <input type="checkbox"/> Convulsions          |
| <input type="checkbox"/> Sinusitis                   | <input type="checkbox"/> Severe Menstrual Pain         | <input type="checkbox"/> Intestinal Disorders |
| <input type="checkbox"/> Other-Please Specify: _____ |  |   |

**CHILDHOOD DISEASES: CHECK IF APPLICABLE**

- |                                      |                                  |                                |   |
|--------------------------------------|----------------------------------|--------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> German Measles |
|--------------------------------------|----------------------------------|--------------------------------|---|

**ALLERGIES & IMMUNIZATIONS: CHECK IF APPLICABLE**

<u>Allergies</u>	<u>Treatment &amp; Reaction</u>	<u>Immunization</u>	<u>Year Primary Series Completed</u>	<u>Year of Last Booster</u>
<input type="checkbox"/> Hay Fever	_____	DPT	_____	_____
<input type="checkbox"/> Asthma	_____	Diphtheria		
<input type="checkbox"/> Drugs	_____	Pertussis(Whooping Cough)		
<input type="checkbox"/> Insect Stings	_____	Tetanus		
<input type="checkbox"/> Poison Ivy	_____	Oral Polio	_____	_____
<input type="checkbox"/> Poison Oak	_____	Measles	_____	_____
<input type="checkbox"/> Food	_____	Mumps	_____	_____
<input type="checkbox"/> Animals	_____	Hepatitis B	_____	_____

**COMMENTS (WHERE APPLICABLE)**

Operations, serious injuries, or concussions (dates): \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Subject to fractures, sprains, or dislocations? \_\_\_\_\_

- |                                   |   |                                       |                                       |
|-----------------------------------|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Menstruation | <input type="checkbox"/> Constipation |
|-----------------------------------|---|---------------------------------------|---------------------------------------|

Other: \_\_\_\_\_

Regular medication (on troop trips medicine MUST be in pharmacy container with name and directions for administering on the label).  
\_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

**(IS PAGE 1 COMPLETE?)**

**-THANK YOU-**

**THIS RECORD IS TO BE RETAINED BY THE TROOP LEADER FOR ONE YEAR AND ACCOMPANY THE ADULT IN CHARGE AT ALL TROOP MEETINGS AND OTHER ACTIVITIES (i.e. field trips, troop camping, etc)**