

Girl Health & Emergency Medical Authorization Form



Parent/Guardian, this form must be completed by you and must travel with your girl.

NAME:	BIRTHDATE:
ADDRESS:	HOME PHONE:
CITY:	STATE: ZIP:
PARENT(S)/GUARDIAN(S)	
NAME:	CELL PHONE:
PLACE OF WORK:	WORK PHONE:
NAME:	CELL PHONE:
PLACE OF WORK:	WORK PHONE:
People who CAN NOT pick up my child:	
If parents CAN NOT be reached, Call:	
Address:	Phone:
Family Health Ins. Co.	Relationship:
Family Physician :	Policy #:
Dentist:	Phone:
	Phone:

IMMUNIZATION RECORDS

Immunization	Year Primary Series Completed	Year of Last Booster	Immunization	Year Primary Series Completed	Year of Last Booster
DPT			Oral Polio		
TB			Meningococcal		
MMR			PCV7		
Hib			Varicella		
Hep B			Tetnus		

HEALTH HISTORY

• Allergies:
• Childhood Diseases:
• Special Problems or Significant Illness:
• Special Diet:
• Activity restrictions:
• Medications to be taken while at activity:
Comments/Suggestions:
▪ Operations or Hospitalizations (include year):
▪ Recent illness or exposure to contagious disease? Yes No
Details:

PARENT CONSENT: This health history is complete and accurate. I know of no reason (s), other than the information indicated on this form, why my daughter/charge should not participate in prescribed activities except as noted. I give permission for my daughter/charge to receive routine health care, over the counter drugs, and prescription drugs administered by appropriate staff, emergency medical and surgical treatment, and to be hospitalized if necessary. In the event of an emergency it is understood that every effort will be made to reach me or the person(s) listed above. It is understood this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage the program leader and said physicians to exercise her/his best judgment as to requirements of such diagnosis or treatment. This permission shall remain in effect from _____ to _____ unless sooner revoked in writing by myself.

SIGNATURE (REQUIRED)

Date