Girl Scouts—Dakota Horizons
1101 S Marion Rd, Sioux Falls, SD 57106
605-336-2978 or 800-666-2141 Fax 605-336-6841
www.gsdakotahorizons.org

Health and Permission Card

This side to be completed by parent/guardian and reviewed with physician at the time of examination.

Name (Last, First, Initial)	Parent or Guardian	Date of Birth	Age
Address	City	State	Zip Code
(Area Code) Phone	Cell Phone	E-mail Address	
Emergency Contact	Emergency Phone	Troop # (5 digit #) ___ ___ ___ ___ ___	

HEALTH HISTORY (Check those that apply)

Allergies (Specify)
- □ Animals _____
- □ Foods _____
- □ Hay Fever_____
- □ Insect Stings_____
- □ Medicine/Drugs (list) _____
_____
- □ Plants_____
- □ Pollen_____

Chronic or Recurring Illness
- □ Ear Infections
- □ Heart Defect/Diseases
- □ Seizures
- □ Bleeding/Clotting Disorders
- □ Asthma
- □ Hypertension
- □ Diabetes
- □ Musculoskeletal Disorder
- □ Other (Specify) _____

Other Health Conditions
- □ Bed Wetting
- □ Constipation
- □ Menstrual Cramps
- □ Motion Sickness
- □ Nosebleeds
- □ Sleep Disturbances
- □ Emotional Disturbances
- □ Fainting
- □ Hearing Impairment
- □ Sickle Cell Trait or Disease
- □ Special Dietary Needs
- □ Wears Glasses or Contact Lenses
- □ Other (Specify) _____
_____
_____
_____

Year of last tetanus booster _____

Is applicant's immunization record up to date? YES or NO

Date of last health examination _____

List daily medications _____

_____

Please explain any items that are checked above. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted. _____

_____

Doctor _____ **Preferred Hospital** _____

Insurance Provider _____ **Policy Number** _____

PARENT/GUARDIAN AUTHORIZATION: This health history is complete and accurate, and the person herein described has my permission to engage in all prescribed activities, except as noted by me. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician named above, or if not available, to the physician selected by the adult in charge, to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above. **Please update and sign annually.**

DATE _____ PARENT/GUARDIAN SIGNATURE _____

DATE _____ PARENT/GUARDIAN SIGNATURE _____

DATE _____ PARENT/GUARDIAN SIGNATURE _____

DATE_____ PARENT/GUARDIAN SIGNATURE_____

~ HOLD HARMLESS AGREEMENT ~

I hereby release and hold harmless Girl Scouts—Dakota Horizons from any and all claims or liability arising from, out of or associated with my child's participation in the activity (s) listed on this card. My signature should be placed next to each event on the back of this form evidencing my release of the Council, its agents and employees as to that specific activity.

Parent/Guardian Signature_____ Date _____

(OVER)

Parent or Guardian Permission for Participation in Girl Scout Activities

Leader's Name_____ Troop # ___ ___ ___ ___ ___

Leader's Phone Number _____Cell Number_____

My daughter has permission to participate in the Girl Scout activity listed below. I will make sure she does not attend if she is not feeling well.

Activity	Date	Place	Cost
1.			

Parent/Guardian Signature _____ Date _____

2.			

Parent/Guardian Signature _____ Date _____

3.			

Parent/Guardian Signature _____ Date _____

4.			

Parent/Guardian Signature _____ Date _____

5.			

Parent/Guardian Signature _____ Date _____

6.			

Parent/Guardian Signature _____ Date _____

7.			

Parent/Guardian Signature _____ Date _____

8.			

Parent/Guardian Signature _____ Date _____

9.			

Parent/Guardian Signature _____ Date _____

10.			

Parent/Guardian Signature _____ Date _____

Parent/Guardian Emergency Phone Number _____

Emergency Contact _____ Phone _____