

**Health History, Emergency Contact Information
Permission to Treat with First Aid and Medical Authorization**

Name of Child: _____
Address: _____
_____ Zip code _____

Mother/Guardian's Name: _____
Day Phone () _____ Evening Phone () _____
Father/Guardian's Name: _____
Day Phone () _____ Evening Phone () _____
Emergency Contact's Name _____
(Relationship to child) _____
Day Phone () _____ Evening Phone () _____

**Keep this form with
the Leader's copy of
the Girl Registration
form for
Parent/Guardian
contact information!**

PLEASE FILL OUT EITHER SECTION ONE (CONSENT FOR MEDICAL TREATMENT) OR SECTION TWO (REFUSAL OF CONSENT FOR TREATMENT). THE REVERSE SIDE OF THIS FORM CONTAINS MEDICAL HISTORY INFORMATION WHICH SHOULD BE COMPLETED AND ACKNOWLEDGED BY THE PARENT OR GUARDIAN OF THE MINOR CHILD.

Section 1

Authorization to permit medical treatment. By signing below, I hereby give permission to the Girl Scouts of Ohio's Heartland Council, Inc. (Girl Scouts), their employees, members, or volunteers to provide routine first aid and to supervise self-medication and to seek medical assistance on behalf of my child in the event my child is injured or becomes ill, and I am unavailable to indicate my wishes regarding treatment. I understand that the Girl Scouts and its members, volunteers, or employees shall not be held responsible for the cost of treatment, and in fact are authorized to bind me as the financially responsible party for the medical treatment of my child. I hereby grant permission to physicians and other licensed health care providers and their designees to administer medical care through injury or illness evaluation, first aid care, and referral to duly licensed medical personnel when indicated.

I AUTHORIZE THE RELEASE OF ALL INFORMATION ON THE REVERSE TO TREATMENT PROVIDERS, AND WILL HOLD THE GIRL SCOUTS IN NO WAY RESPONSIBLE FOR THE RELEASE OF THIS INFORMATION TO ANY PARTY.

_____ Date Granted _____ Signature of Parent or Guardian

Medical Insurance Coverage Provider(s) _____

Section 2

Refusal to consent to medical treatment. By signing below, I indicate that the Girl Scouts of Ohio's Heartland Council, Inc. (Girl Scouts), its volunteers, or employees are ***not*** authorized to allow the administration of health care to my child in the event of injury or sickness. However, I will not hold the Girl Scouts, its employees, members, or volunteers liable in any way for seeking emergency care (such as calling 911) for my child or providing any health information on this form to emergency personnel.

_____ Date Refused _____ Signature of Parent or Guardian

MEDICAL HISTORY INFORMATION MUST BE COMPLETED ON THE REVERSE SIDE OF THIS FORM.

