FRONTIER GIRLS PERSONAL HEALTH AND MEDICAL FORM

IMPORTANT: YOU MUST COMPLETE AND RETURN TO YOUR PROGRAM LEADER

NAME: _____ DATE OF BIRTH: _____/_____/_____

PARENT'S NAME: _____ PROGRAM LEVEL: _____

ADDRESS: _____ HOME PHONE: _____

CITY: _____ _ STATE: _____ ZIP: _____

IN CASE OF EMERGENCY, NOTIFY:

NAME: _____ RELATIONSHIP: _____

PHONE: _____ INSTRUCTIONS: _____

FAMILY PHYSICIAN: _____ **PHONE:** _____

PERSONAL HEALTH INSURANCE CARRIER: _____

MEDICAL RESTRICTIONS OR DIFFICULTY:

____ Allergies ____ Asthma ____ Bee Stings ____ Convulsions ____ Diabetes ____ Fainting Spells
____ Heart Condition ____ Sports Restrictions ____ Other Restrictions ____ No Restrictions
____ Eyes ____ Ears ____ Nose ____ Throat ____ Digestion ____ Lungs ____ Other

Explain Restrictions or Difficulties: _____
_____
_____

Does the member take medication? If so, what kind:

_____

IMMUNIZATIONS: (Inoculations should be all current, if not, please indicate the ones that are not)

_____
_____

I give permission for full participation in the Frontier Girls Troop 377 scout program, subject to the limitations noted herein. In case of emergency, I understand every effort will be made to contact me or the emergency person. If neither be reached, I hereby give my permission to the medical staff selected by the adult leader in charge to secure proper treatment for my child, including hospitalization, anesthesia, surgery, or injections of medication.

PARENT SIGNATURE: _____ DATE: _____