

## Health and Medical Form

- Each year, AHG Girl and Adult Members complete a new or update an existing *Health and Medical Form* kept on file at the Troop level.
- Attaching a photo to the *Health and Medical Form* can help to avoid errors in identification.

Troop Number						
Member Name						
Date of birth				Age		
Weight				Height		
Address						
City				State		Zip Code
Parent/guardian Name(s)						
Phone Number						
Emergency Contacts	Name					
	Relationship					
	Phone Number					
	Name					
	Relationship					
	Phone Number					
Allergies: If applicable, please list all known allergies including medications, food, and environment.	Allergy	Normal reaction and management of reaction				
General Health Information: Check all that apply, past or present, to you or your daughter's health history.	Abdominal/stomach/digestive problems Asthma Convulsions/seizures COPD Diabetes Excessive fatigue Fainting or dizziness Head injury/concussion			Lung/respiratory disease Menstrual cramps Migraines/headaches Motion/altitude sickness Muscular/skeletal conditions/muscle or bone issues Neurological disorders Nosebleeds Sinus problems		

	Heart disease/heart attack/chest pain/heart murmur/coronary artery disease Hemophilia or blood disorders Hypertension (high blood pressure) Kidney Disease	Sleep apnea, sleepwalking or sleep disorders Stroke/TIA Thyroid disease
--	---	---

Additional notes about the member's behavior, physical, emotional or mental health needs pertinent to their participation in American Heritage Girls.	
---	--

<b>Tetanus Immunization Policy:</b> AHG requires members to have Tetanus immunization within the last 10 years.	_____ I (or my daughter) has received tetanus immunization on _____ (date).  _____ I (or my daughter) have not received tetanus immunization and would like to request exemption based upon a lack of immunization records, religious, philosophical or medical grounds.  Signature of individual or parent/guardian: _____
--	---

The following immunizations are recommended by AHG, Inc. but are not required.

Immunization	Year Received
Pertussis	
Diphtheria	
Measles/mumps/rubella	
Polio	
Chicken pox	
Hepatitis A	
Hepatitis B	
Meningitis	
Influenza	



I give permission for full participation in American Heritage Girls programs, events and activities, subject to limitations noted herein. I know of no health reason(s), other than the information indicated in this form, why I or my daughter should not participate in any of the American Heritage Girls activities.

Please initial one:

\_\_\_\_\_ In case of an emergency, I understand every effort will be made to contact me (or my next of kin). In the event that contact cannot be made, I hereby give my permission to the licensed health-care provider selected by my Troop or Charter Organization to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for myself or my child, except as noted. I agree to the release of records necessary for treatment.

\_\_\_\_\_ I **do not** give my consent for medical treatment of my daughter or I. In the event of illness or injury requiring treatment, I wish AHG volunteers to take **no action** beyond basic first-aid measures.

Additional notes:

Signature of individual or parent/guardian

Date

### Medication and Request for Administration of Medication

Please list all medications currently used, including any over-the-counter medications. If additional medications are added at any time, including short term prescriptions or over-the-counter treatments, please complete an additional or new *Medication and Request for Administration of Medication Form*.

\_\_\_\_\_ Check here if no medications are routinely taken.

Name of medication	Diagnosis or reason the medication is needed	Prescription Medication	Nonprescription Medication	Topical Product or Lotion	Supplement	Refrigeration Required	Emergency medication to be kept on person	Dosage	To be administered at the following times:	For the following period of time:	Restrictions or reactions, if any, and necessary emergency response:

If additional medications are needed, please attach additional documentation.

Non-prescription medication administration is authorized with these exceptions:

I authorize the AHG Health and Safety Lead for the meeting, trip, event or activity to administer the above medications as prescribed by my child's health care provider. If the medication is an over-the-counter medication, I authorize its use according to the provided instructions. If I am unable to be contacted, I authorize the Troop to contact my child's health care provider as needed regarding this medication and/or my child's response.

Parent/guardian signature: \_\_\_\_\_

MD/DO, NP, or PA signature (if your state requires signature): \_\_\_\_\_

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