



MEMBER NAME: _____

EMERGENCY #: _____

American Heritage Girls Troop GA3106 Oconee Heights Baptist Church

Girl Health & Medical Form

This form is required to be kept updated yearly or as needed and on file at all Troop events. All medical information is kept private and only released if medically necessary.

Girl Information

FULL NAME: _____

ADDRESS: _____

BIRTHDAY: _____ ALLERGIES: NO YES (please list on page 2)

Parent/Legal Guardian Information

NAME: _____

RELATIONSHIP: FATHER MOTHER GRANDPARENT OTHER: _____

ADDRESS: _____

EMAIL: _____

PHONE: _____

AHG ADULT: YES NO

BEST CONTACT METHOD: CALL TEXT
 EMAIL

NAME: _____

RELATIONSHIP: FATHER MOTHER GRANDPARENT OTHER: _____

ADDRESS: _____

EMAIL: _____

PHONE: _____

AHG ADULT: YES NO

BEST CONTACT METHOD: CALL TEXT
 EMAIL

Emergency Contacts

NAME: _____

NAME: _____

RELATIONSHIP: _____

RELATIONSHIP: _____

PHONE: _____

PHONE: _____



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Other Adults Authorized to Take Youth To and From Events:

NAME:	PHONE:	RELATIONSHIP:

Adults NOT Authorized to Take Youth To and From Events:

NAME:	PHONE:	RELATIONSHIP:

Insurance/Medical Coverage

PROVIDER: _____

POLICY HOLDER: _____ POLICY #: _____

EFFECTIVE DATE: _____ GROUP #: _____

ATTACH PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD(S)

Physician Information

PRIMARY PHYSICIAN: _____ PHONE: _____

DENTIST: _____ PHONE: _____

PREFERRED HOSPITAL: _____

Allergies

Please list all known allergies (medications, food, environmental, etc.), typical reaction and usual treatment.

ALLERGY:	REACTION:	TREATMENT:



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Existing Medical Conditions

Check all that apply to your child.

- Anxiety
- Asthma
- ADD/ADHD
- Autism Spectrum Disorder
- Convulsions/seizures
- COPD
- Depression
- Diabetes
- Excessive fatigue
- Fainting or dizziness
- Head injury/concussion
- Heart attack/chest pain
- Heart murmur/Coronary Artery Disease
- Hemophilia or Blood disorders
- Hypertension (High Blood Pressure)
- Kidney Disease
- Lung/Respiratory disease
- Menstrual Cramps
- Migraines/Chronic headaches
- Motion/Altitude sickness
- Muscular/Skeletal Conditions
- Neurological Disorders
- Nosebleeds
- PTSD
- Sinus Problems
- Sleep Apnea
- Sleepwalking
- Stroke/TIA
- Thyroid Disease
- Other (please list below)

Additional Notes about the member’s behavior, physical, emotional or mental health needs pertinent to their participation in American Heritage Girls:

Medications

- No medications routinely taken
- The medications listed below are regularly taken (including inhalers, Epi-Pens, over the counter medications, homeopathic, and prescription medications). If medications of any type will be taken or needed during Troop meetings, events, activities or trips, please fill out the **Request for Medication Administration Form**. If additional lines are needed, please attach a separate page.

MEDICATION:	DOSAGE:	PURPOSE:
_____	_____	_____
_____	_____	_____



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Tetanus Immunization

AHG policy requires all registered members to have Tetanus immunization within the last 10 years.

- My daughter has received tetanus immunization on: _____
- My daughter has not received tetanus immunization and would like to request exemption based upon a lack of immunization records, religious, philosophical or medical grounds.

SIGNATURE OF PARENT/GUARDIAN: _____

Recommended Immunizations

Please list the year of last immunization of each type or attach your child's immunization record.

IMMUNIZATION:	YEAR RECEIVED:
Pertussis	
Diphtheria	
Measles/Mumps/Rubella	
Polio	
Chicken Pox	
Hepatitis A	
Hepatitis B	
Meningitis	
Influenza	

Release for Medical Treatment

I give my 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 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 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. In the event of illness or injury requiring treatment, I wish AHG volunteers to take no action beyond basic first-aid measures.



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Permission for Participation in Regular Meetings

As the parent/guardian I authorize my daughter to participate in Troop Meetings, typically held on Tuesday evenings at Oconee Heights Baptist Church, for the duration of the current Program Year. I understand I will be asked to give express individual permission for any additional Troop activities, trips or events beyond regular meetings.

SIGNATURE OF PARENT/GUARDIAN: _____

I hereby attest to the correctness and authenticity to the information herein about my child.

SIGNATURE OF PARENT/GUARDIAN

DATE COMPLETED

Please complete and return to American Heritage Girls Troop GA3106 via US Mail or in person along with a photocopy of front and back of the child's healthcare/insurance cards.

PLEASE DO NOT SCAN OR EMAIL THIS FORM - Mail or bring in person.

AHG Troop GA3106
c/o Oconee Heights Baptist Church
4180 Jefferson Road
Athens, GA 30607