



PERSONAL HEALTH FORM For Girl/Youth Members

Note to Parent/Guardian

- 1. The information on this form may be used by GGC representatives or medical personnel to administer or authorize appropriate health care or medical attention for the participant, if needed.
2. Parent/guardians return this form to the responsible Guider. You may be asked to review and update this form periodically throughout the year.
3. It is also recommended that you attach a photo on the reverse side of this form.

Name Last name Given name
Birth date year/month/date Height Weight
Address No. Street Apt. No. P.O. Box or R. R. No.
City Province Postal Code
Phone: Home () Business ()

Contact information of custodial parent or guardian: E-mail
Surname Given Name
Address (if different from above)
No. Street Apt. No. P.O. Box or R. R. No.
City Province Postal Code

If the above are unavailable in an emergency, please notify:
1. Surname Given Name Relationship
Address (if different from above)
No. Street Apt. No. P.O. Box or R. R. No.
City Province Postal Code
2. Surname Given Name Relationship
Address (if different from above)
No. Street Apt. No. P.O. Box or R. R. No.
City Province Postal Code

1. Family doctor Phone ()
2. The activity/event/camp may include swimming hiking, boating, pitching tents, etc. Does the participant have any physical, cognitive, emotional or behavioural limitations/challenges that would require assistance and/or modifications to the program to enable her to participate fully? Yes No
If yes, please state particulars:

3. Do you have any special instructions for Guiders/staff regarding the participant's health care and/or diet? Yes No
If yes, please explain:

4. Has this person menstruated? Yes No If not, has she been told about it? Yes No
5. Are corrective lenses required? Yes No Contact lenses? Yes No

Participant's name:

Site/event:

Year:



Name of participant: _____

6. If the participant has allergic reactions to such things as food, insect stings, etc., please complete the following:

<i>Allergy</i>	<i>Life-Threatening?</i>	<i>Allergy</i>	<i>Life-Threatening?</i>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Is the participant subject to any of the following? (*Please check all that apply*)

Arthritis Convulsions Motion sickness Other – please specify? _____

Respiratory ailments Ear trouble Nightmares _____

Bed wetting Headaches Sleepwalking _____

8. Chronic conditions or recent illnesses of which the Guiders/staff should be aware: _____

9. Please provide details of treatment required and name of medications she will be bringing with her if required for the above mentioned condition(s). _____

10. Are there any medications that your child/ward should carry themselves (e.g., asthma pump, Epi-pen).
 Yes No If yes, please specify: _____

Medications: Any medication (over-the-counter and/or prescribed) required by girl Members must be brought with her in original packaging with dosage instructions and clearly labeled with her name. Medications are given to the Guider or first aid provider upon arrival at the activity/event/camp for storage. The Guider or first aid provider will supervise the taking of medication by girls according to instructions provided. Participants must be willing to take their medication. They will not be given any medication that is not provided by parents/guardians.

Other comments: _____

Note: *If the participant has been treated by a physician for an illness or injury within one month of the date of the activity, the **Wellness Statement (OA.3)** must be completed and signed by a physician.*

N. B. Every care and attention will be given to the health and comfort of the participant.

I hereby authorize a Girl Guides of Canada representative to secure such medical advice and services (e.g., contacting EMS/ambulance) as may be deemed necessary for the health and safety of myself or my daughter (or ward) during activities. I agree to accept financial responsibility in excess of the benefits allowed by my provincial/territorial health plan or the Girl Guides of Canada insurance plan:

Date: _____

Signature of Participant (or custodial parent/guardian if participant is under provincial/territorial age of majority)

UPDATED: _____ Date: _____

Signature of Participant (or custodial parent/guardian if participant is under provincial/territorial age of majority)

This form is valid for one year. Update may be required during this period.

Space for Photograph

A picture is required when a girl/youth Member is attending any activity/event/camp at which she may not be known (e.g., area camps, outings, district rallies, etc.)

I am aware of the extent of the proposed activity and this participant is fit and healthy enough to participate fully. I certify that the information on this form is complete, correct and current.

Signature of physician
(Physician signature is only required for Level 4 activities that have an EMS response time of more than four hours).

Date: _____
Signature must be obtained annually within approximately two months of first activity/event/camp requiring this signature.

We protect and respect your privacy. Your personal information is used only for the purposes stated on or indicated by the form. For complete details, see our Privacy Statement at www.girlguides.ca or contact your provincial/territorial office or the national office for a copy.