

Adult Health History Record

Completed form can be saved, printed, and/or submitted through e-mail.
 Leaders should keep this form in their records and bring to all events.

Adult's Information

name		daytime phone	evening phone	
date of birth	age	e-mail		
address		city	st	zip

Emergency Contact & Insurance/Physician

name		relationship	phone	
address		city	st	zip
physician's name		phone		
insurance provider		policy / group #		

Illnesses & Injuries, Chronic or Recurring Illness

Check all that apply.

<input type="checkbox"/> Ear infection	<input type="checkbox"/> Bleeding / clotting disorder	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart defect / disease	<input type="checkbox"/> Musculoskeletal disorder	<input type="checkbox"/> Seizure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Intestinal disorders	<input type="checkbox"/> Hernia	<input type="checkbox"/> Nervous system disorders	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Chicken Pox			
<input type="checkbox"/> Other:			

Allergies

Check all that apply, and specify the nature of allergic reaction.

<input type="checkbox"/> Animals:	<input type="checkbox"/> Medicine / drugs:	<input type="checkbox"/> Food:
<input type="checkbox"/> Insect stings:	<input type="checkbox"/> Plants:	<input type="checkbox"/> Hay fever:
<input type="checkbox"/> Pollen:	<input type="checkbox"/> Other:	

Other Health Conditions

Check all that apply.

<input type="checkbox"/> Emotional disturbances	<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Sickle cell trait or disease
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Wear glasses or contact lenses
<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Special dietary needs	<input type="checkbox"/> Eyesight impairment	<input type="checkbox"/> Speech impairment
<input type="checkbox"/> Other:			

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Indicate any activities to be encouraged or restricted. Please attach additional documentation as needed.

Signatures

Yes, this health history is correct, and I am able to engage in all prescribed activities except as noted above.

adult signature

date

Yes, in case of illness or injury while on a Girl Scout activity, I give my consent for emergency medical treatment in the emergency room of the nearest hospital.

adult signature

date

Yes, I give my consent for certified First Aiders to administer first aid treatment in case of illness or accident while on a Girl Scout activity.

adult signature

date