Please Print SU# ______ Troop# ____________

Name____ ☐ Female ☐ Male

Address____

Street Apt. # City State Zip

Telephone ______________________ Email Address ______________________

Emergency Contact: Must Have 2

Name ______________ Day/Evening Telephone ______________ Relationship ________

Name______________ Day/Evening Telephone ______________ Relationship ________

Name of family DENTIST: ______________________Telephone ______________

Name of family PHYSICIAN:______________________ Telephone ______________

Family Medical/Hospital INSURANCE CARRIER ____________ Policy or Group # ____________

Part I: Illnesses and Injuries (check all for which treatment has been received and give appropriate dates)

☐ Asthma __________
☐ Bleeding/Clotting Disorders __________
☐ Conditions of the bones or joints __________
☐ Convulsions __________
☐ Diabetes __________
☐ Ear Infection __________
☐ Epilepsy __________
☐ Heart Defect/Disease__________
☐ Hypertension __________
☐ Lung Disease __________
☐ Kidney Disease_________

☐ Other (specify) ____

In the past 5 years, have you

_____ had a serious injury requiring medical attention?
_____ had surgery of any kind?
_____ taken any medication on a regular basis?
_____ been treated in emergency room of a hospital?
_____ had an illness lasting more than 2 weeks?
_____ had a fracture?
_____ been admitted to a hospital for treatment
_____ been restricted from participating in any physical activity for an extended period?

If you said yes to any of the questions above, please explain in the space below

Part II: Allergies (Check those that apply and treatment) ☐ **Check Here for No Known Allergies**

☐ Animals __________________
☐ Plants ___________________
☐ Insect Stings ______________
☐ Medicines/Drugs __________________
☐ Hay Fever ______________________
☐ Other (specify)________________________________
☐ Food __________________
☐ Pollen _________________

Part III: Other Health Conditions (Check those that apply)

☐ Attention Deficit Disorder (ADD)
☐ Arthritis
☐ Abnormal Blood Pressure
☐ Down's syndrome
☐ Emotional Disturbances
☐ Fainting
☐ Hearing Impairment
☐ Menstrual Cramps
☐ Motion Sickness
☐ Nosebleeds
☐ Obesity
☐ Sickle Cell Trait or Disease
☐ Sleep Disturbances
☐ Special Dietary Needs
☐ Visual Impairment
☐ Wears Glasses or Contact Lenses
☐ Wears Hearing Aid
☐ Other (specify) ______________________

Part IV: Immunization History

Date of last known Tetanus shot _________________ Other (specify)____________________________

Activity Restrictions ____

Health Information Privacy Statement

The Adult Health History Record is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

I know of no reason(s) other than those indicated on this form, why I should not participate in general Girl Scout activities, except as noted.

Signature: ____ Date______________________

2/09