



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 \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Ear Infection \_\_\_\_\_
- Epilepsy \_\_\_\_\_
- Heart Defect/Disease \_\_\_\_\_
- Hypertension \_\_\_\_\_
- Lung Disease \_\_\_\_\_
- Kidney Disease \_\_\_\_\_

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 \_\_\_\_\_