



Girl Scouts

ADULT HEALTH HISTORY RECORD

This health history is to be completed and signed by the adult members themselves

Name	Date of Birth	Age
Address	Troop No.	
Address	Phone ()	
Business Name		
Business Address	Phone ()	
Emergency Contact Name	Relationship	
Address	Phone ()	
Name of Family Physician	Phone ()	
Family Insurance Carrier	Policy No.	

Part I: Illnesses and injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness

- Ear Infection Bleeding/Clotting Disorders Hypertension Asthma Other (specify) _____
 Heart Defect/Disease Musculoskeletal Disorders Seizures Diabetes _____

Date of last health examination: _____

Were any complicating medical problems noted in last examination? _____

Is participant currently under the care of a physician or psychologist? _____

Since last health exam, has participant had:

- | | |
|--|--|
| A serious injury requiring medical attention? _____ | An illness lasting more than five days? _____ |
| Any prescribed or over-the-counter medication? _____ | A surgical operation or fracture? _____ |
| Treatment in a hospital or emergency room? _____ | Any restrictions concerning physical activities? _____ |
| Any exposure to a contagious disease? _____ | Other? _____ |

Please explain any "yes" answers to the above questions. Include dates: _____

Part II: Allergies (check those that apply and specify nature of allergic reaction.)

- Animals _____ Hay Fever _____
 Pollen _____ Food _____
 Medicines/Drugs _____ Insect Stings _____
 Plants _____ Other(Specify) _____

Part III: Other health conditions (check those that apply)

- Constipation Fainting
 Menstrual Cramps Hearing impairment
 Motion sickness Sickle cell trait or disease
 Nosebleeds Special dietary regimen
 Sleep disturbances Wears glasses or contacts
 Other (specify) _____

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

Part IV: Immunization History

Immunization	Year primary series completed	Year of last booster
D.T.P.	_____	_____
Diphtheria	_____	_____
Pertussis (whooping cough)	_____	_____
Tetanus	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
(German Measles)	_____	_____
Oral Polio	_____	_____
Hbpv	_____	_____
Tuberculin test (most recent)	Result	_____
Other	_____	_____

This health history is correct and I am able to engage in all prescribed activities except as noted.

Signature of adult _____

Date _____