Adult Health History

This health history record/consent for emergency medical treatment form should be completed by any adult participating in troop activities and returned to the troop leader in an envelope with adult's name written on outside. The troop leader will keep this form with the troop's permanent files. For each additional Girl Scout year please have parents review and make the necessary updates, initial and date the last page of the form. Please complete a new form if there are numerous or important changes

Adult's Name ______________________________

Address ______________________________

City ____________________ State __________ ZIP __________

Daytime Phone ______________ Evening Phone ______________

Cell Phone ______________ Email ______________

Emergency Contact Information:

Name ____________________ Relationship ______________

Phone number(s) ______________________________

Physician/Insurance Information

Name of family physician ____________________ Phone ______________

Name of family dentist/orthodontist____________________ Phone ______________

Family medical/hospital insurance carrier ______________________________

Policy or Group number ______________________________

Part I: Illness and injuries (check all that apply)

❑ Ear infection ❑ Bleeding/clotting disorders ❑ Hypertension ❑ Asthma
❑ Heart defect/disease ❑ Musculoskeletal disorders ❑ Seizures ❑ Diabetes
❑ Hypoglycemia ❑ Other: ______________________________
Date of last health examination: ______________________________
What, if any, complicating medical problems were noted? ______________________________

Part II. Allergies (check all that apply and specify the nature of the allergy)

❑ Animals ❑ Insect Stings: ________ ❑ Hay Fever/Pollen
❑ Plants ❑ Food: ______________________________
❑ Medicine/Drugs: ______________ ❑ Other: ______________

Part III. Other Health Conditions (check all that apply)

❑ Constipation ❑ Fainting ❑ Hearing Impairment ❑ Menstrual Cramps
❑ Motion sickness ❑ Nosebleeds ❑ Sickle Cell trait/disease ❑ Special Diet regimen
❑ Sleep disturbances ❑ Glasses or contacts ❑ ADD & ADHD ❑ Other: ______________

If you checked any of the above, please explain any details we should know: ______________

____

Northern Indiana Service Center: 10008 Dupont Circle Drive E, Fort Wayne, IN 46825 800.283.4812
Michiana Service Center: 1218 E University Drive, Granger, IN 46530 Fax: 855.422.0084
www.gsnim.org

Part IV. Immunization History

	Year of last booster
Tetanus	______________________________
Other	______________________________

Part V. Current Medications

This person ❑ takes **NO** medications on a routine basis
❑ Takes prescription/over-the-counter medications as follows:

Med #1 ______________________ Dosage ___________ Specific times taken each day __________

Reason for taking ____

Med #2 ______________________ Dosage ___________ Specific times taken each day __________

Reason for taking ____
Attach additional pages for more medications or additional medication information.

Consent for Emergency Medical Treatment

I do hereby state that in case of my unconsciousness and unavailability of my emergency contact, I authorize the Girl Scout leader or adult in charge to consent to any necessary health care including: examination, medical diagnosis, anesthetic, surgery, or other treatment, and/or hospital care to be rendered to me under the supervision of and/or advice of a licensed physician.

Adult's Signature ____ Date __________

Please use this area to further explain any items checked and provide any information that would be useful to the adult(s) in charge. Please also tell us about any activities that should be encouraged or restricted.

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Adult initials that information on this form is still current ___________________Date_______________

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