girl scouts of the colonial coast

Girl/Adult Health History Form

This health history form is to be completed and signed by a girl's caregiver or the adult participant.

This participant is ☐ a girl ☐ or adult.

First Name ___________________________ Middle Name ______________________ Last Name ________________________

Date of Birth __________________________ Phone _________________________________Gender ______________________

Address ____ City ________________________ State _____ Zip _________

Primary Caregiver Name ____ Phone _______________________________

Secondary Caregiver Name ____ Phone ___________________________

Medical Insurance Carrier ____ Policy/Group # ____________________________

Primary Physician Name ____ Phone _______________________________

Part I: Allergies (specify nature of allergic reaction)

☐ Animals _______________________ ☐ Hay Fever _________________________ ☐ Medicine/Drugs ______________________

☐ Food ___________________________ ☐ Insect Stings _______________________ ☐ Plants/Pollen ________________________

☐ Other ____

Part II: Illnesses and Diseases – Chronic or Recurring

☐ Arthritis ☐ Diabetes ☐ Measles ☐ Sinusitis

☐ Asthma ☐ Ear Infection ☐ Musculoskeletal Disorder ☐ Tuberculosis

☐ Bleeding/Clotting Disorders ☐ Heart Defect/Disease ☐ Rheumatic Fever ☐ Other ________________________

☐ Chicken Pox ☐ Hypertension ☐ Seizures ____________________________

Part III: Other Health Conditions

☐ Bed Wetting ☐ Fainting ☐ Motion Sickness ☐ Sleep Disturbances

☐ Constipation ☐ Hearing Impairment ☐ Nosebleeds ☐ Special Dietary Regimen

☐ Emotional Disturbances ☐ Menstrual Cramps ☐ Sickle Cell Trait/Disease ☐ Wear Glasses/Contact Lenses

Part IV: Immunization History

☐ Immunization History is attached. ☐ All immunizations are up-to-date.

Permission to give to participant:

☐ Tylenol/Acetaminophen ☐ Tums/Antacid ☐ Sudafed/Decongestant ☐ Swimmer's Ear or Alcohol/Vinegar Solution

☐ Benadryl/Antihistamine ☐ Advil/Ibuprofen ☐ Robitussin/Expectorant ☐ None

Participant Statement: I certify that to the best of my knowledge this health history is complete and accurate. I know of no reason(s) other than the information indicated on this form, why I/my daughter should not participate in prescribed activities except noted.

Privacy Statement: All health records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. This information will be held in limited access by the troop leader/healthcare supervisor of the event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate safety and healthcare. I have read the above information and agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Caregiver Authorization: If my child needs medical treatment, I authorize the adult in charge, should it be necessary, to secure the service of a doctor at my expense. I give my permission for her to be attended for care. I am aware that I will be contacted in the case of an emergency.

Caregiver/Adult Participant Signature ______________________________________ **Date** __________