



Girl Scouts.

Girl Scout Council of the Nation's Capital
4301 Connecticut Avenue, N.W.
Washington, D.C. 20008
PHONE (202)-237-1670 (800)-523-7898
FAX (202)-274-2161
EMAIL membershipdept@gscnc.org

B230

ADULT HEALTH HISTORY / EMERGENCY MEDICAL AUTHORIZATION FORM

To be filled out by Adult

Return Form to: Troop/Group Leader at or before the first meeting. Must be updated yearly or as changes occur.

Adult's Name (first, middle initial, last) Position

Home address City State Zip

Phones: Day Evening Cell

Emergency Contact: Relationship

Phones: Day Evening Cell

Emergency Contact: Relationship

Phones: Day Evening Cell

Sex: Female Male Optional: Birth Date Age Current Weight Current Height

Health History: (Check all that apply and give approximate dates. Use the Continuation Page as necessary)

- ADD/ADHD, Arthritis, Asthma, Athletes Foot, Bleeding/Clotting Disorders, Bronchitis, Cancer, Colds/Sore Throats, Constipation, Convulsions, Diabetes, Ear Infections, Epilepsy, Fainting, Hay Fever, Headaches/Migraines, Hearing, Heart Defect/Disease, Hypertension, Kidney Disease, Mononucleosis, Motion Sickness, Muscle Disease/Disorder, Nervous System Disorder, Pregnant, Sickle Cell Anemia, Sinusitis, Skeletal Disease/Disorder, Skin Conditions, Sleep Disturbance/Walking, Stomach Upsets, Urinary Tract Infections, Chicken Pox, German Measles, Measles, Mumps, Other, Wears: Contacts Glasses, Allergies: Animals, Bee/Wasp Stings, Plants, Ivy/Oak, Drugs, Foods, Other

Are there any special needs or accommodations required? If yes, please explain

Ever required any psychiatric counseling or hospitalization? If yes, explain

Operations or serious injuries

Disability or chronic or recurring illness

Activities to be encouraged or limited by your physician?

Dietary modifications

Since last health exam have you had: a serious injury requiring medical attention? an illness lasting longer than one week?

an in-patient hospital treatment or the emergency room? been restricted from participating in any activities?

(Please explain any "YES" answers to the above questions and include dates and/or details. May use the Continuation Page if necessary.)

Immunization History: Are all immunizations up-to-date? Yes No If no, please state reason

Give dates for person listed above. Complete other information as requested.

DTP or DT (Tetanus) Date: TB test Date: Results: Date of last health exam:

Insurance Information: Company Policy Number Policy Holder

Company address: City: State

Other: Name of Dentist/Orthodontist: Phone

Name of Physician Phone

Preferred Medical Facility: Location:

Medication Information: Any prescribed medication being taken? No Yes - Inhaler Epipen Other - what, why, when, and dosage?

IMPORTANT - THIS SECTION MUST BE COMPLETED

This health history is correct so far as I know. I can engage in all activities except as noted. I hereby give permission to the First Aider or Adult in charge to provide routine health care and administer prescribed medications. I consent to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my participation in any activity sponsored by GSUSA, GSCNC or individual units. Should a medical emergency arise during my participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact my designated alternate at the phone numbers I have given. If it is believed my life or health may be adversely affected by the delay that an attempt to contact my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied for trips and camping outside of the normal meeting place.

Signature (in ink)

Date

*If for religious reasons you cannot sign this form, then submit a legal waiver, which must be signed for attendance/participation.



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ADULT HEALTH HISTORY / EMERGENCY MEDICAL AUTHORIZATION FORM *Continuation Page*

Use this page to enter any information that would not fit on the previous page.