



Girl Scout Council of the Nation's Capital
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B230

ADULT HEALTH HISTORY 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 and give approximate dates. Attach additional sheets as necessary)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> ADD/ADHD _____ | <input type="checkbox"/> Headaches; Migraines _____ | <input type="checkbox"/> Skeletal disease/disorder _____ | Allergies: |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Skin Conditions _____ | <input type="checkbox"/> Animals _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart defect/disease _____ | <input type="checkbox"/> Sleep Disturbance/ Walking _____ | <input type="checkbox"/> Bee/wasp stings _____ |
| <input type="checkbox"/> Athletes Foot _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Stomach upsets _____ | <input type="checkbox"/> Plants, ivy/oak _____ |
| <input type="checkbox"/> Bleeding/clotting disorders _____ | <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Urinary Tract Infections _____ | |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Mononucleosis _____ | <input type="checkbox"/> Chicken pox _____ | <input type="checkbox"/> Drugs _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Motion Sickness _____ | <input type="checkbox"/> German measles _____ | |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Muscle disease/disorder _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Foods _____ |
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Nervous system _____ | <input type="checkbox"/> Mumps _____ | |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Pregnant _____ | Wears: <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Fainting _____ | <input type="checkbox"/> Sickle Cell Anemia _____ | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Sinusitis _____ | | |

Any Special Needs: If yes, 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 back of form if necessary.)

Immunization History: Are all immunizations up-to-date? Yes No If no, please state reason _____
 Give date of immunization that person listed above has had. 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.