MINOR & ADULT HEALTH HISTORY RECORD

This health history is to be completed and signed by
parents/guardians of minor members or by adult members themselves

Full Name:	**Date of Birth: Age:**
Home Address:	**Troop Number:**
Parent/Guardian Full Name:	**Home Phone:**
Home Address:	**Cell Phone or Pager:**
Business Address:	**Business Phone:**

In Emergency Notify: ______________________________ at ______________________
(Name & Relationship) (Phone number with area code)

If they are not available, notify: ______________________________ at ______________________
(Name & Relationship) (Phone number with area code)

Family Physician: ______________________________ at ______________________
(Name) (Phone number with area code)

Insurance Company Name:______________________ Phone Number: ______________________

Name of Policyholder: ______________________ Policy/Group Number: ______________________

Section 1: Illnesses and injuries (check those that apply and explain below)

Chronic or Recurring illness

___Ear Infection ___Bleeding/Clotting Disorders ___Hypertension ___Asthma
___Heart Defect/Disease ___Musculoskeletal Disorders ___Seizures ___Diabetes
___Other (specify & explain)____

Date of last Health Exam:__________________Were any complicating medical problems or any conditions requiring monitoring or follow-up noted in the last health exam? Explain:______________________________

____

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

Since the last health exam, has participant had:

An injury or medical condition requiring medical attention? _______ An illness lasting more than five days?_______
Any exposure to a contagious disease?_______ A surgical operation or fracture? _______
Treatment in a hospital, outpatient clinic, or emergency room?________Any restrictions of physical activities?_________
Any prescribed or over-the-counter medications? _______ Is participant currently taking any medication?________

Please explain any check marks or "yes" answers to the above questions. Attach an extra sheet if necessary. Be as detailed as possible. Include dates, dosage of medications, etc:

Turn this page over for other important information

Section II: Allergies (Check those that apply and specify nature of allergic reaction in open space below)
___Animals ___Hay Fever ___Pollen ___Food ___Plants ___Insect stings
___Medicine/drugs ______Is participant currently taking any allergy medication?
___Other (Specify) ____
******Explain any checks. Also, please specify type of reaction and symptoms noted, and any particular treatment in case of exposure to allergy or allergic reaction:**

Section III: Other Health Conditions (Check those that apply explain in open space below)

___Bed wetting	___Emotional disturbances	___Constipation	___Fainting
___Menstrual cramps	___Motion sickness	___Hearing impairment	___Nosebleeds
___Sleep disturbances	___Dietary restrictions	___Glasses/contact lenses	___Anemia

______Other (Specify)
******Explain any checks:**

Section IV: Immunization History – Attach a copy of current Immunization History to this form.
You may attach a copy of the school immunization form available from your physician or your local health center.

Section V: Over the counter medications
You may use this space to indicate any over the counter medications that your daughter is allowed to take if necessary. Please indicate the usual dosage that you would administer. Only the adult certified in First Aid or other adult in charge of activity will be allowed to administer the medication based on your instructions. Any medications, along with written instructions for dosage, that your daughter must take while participating in a Girl Scout Activity must be given to the adult certified in First Aid or other adult in charge of activity prior to departure. The only exceptions to this shall be PRN inhalers or epi-kits that your daughter has been trained to self-administer (adult certified in First Aid and other adults in charge of activity must be made aware if your daughter is carrying such item).

FOR MINOR PARTICIPANTS

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted. If this information changes during the Girl Scout year I will notify the leader in writing. I understand that this information will remain confidential to the troop/group/program leaders, designated person trained in first aid, or emergency personnel as needed.

____ ______________________________

(Signature of parent or legal guardian) **(Date this form was signed)**

FOR ADULT PARTICIPANTS

This health history is complete and accurate. I am able to participate in prescribed activities except as noted. If this information changes during the Girl Scout year I will notify the leader in writing. I understand that this information will remain confidential to the troop/group/program leaders, designated person trained in first aid, or emergency personnel as needed.

____ ______________________________

(Signature of adult participant) **(Date this form was signed)**