



Girl Scouts.
Where Girls Grow Strong.



Girl & Adult Health History Form - Confidential

This health history is to be completed and signed by parents/guardians of girls or by adult members themselves. *NOTE: A health history is required for participation in physically demanding activities, such as water sports, horseback riding, or skiing. A trip lasting more than three nights requires a health examination in addition to a health history, GSHNC approval, and additional insurance coverage. (See *Safety Wise* – Pages 39 & 153).

Name	Date of Birth	Age
Address	Troop No.	
Parent/Guardian	Home Phone	
Home Address	Work Phone	
Business Address	Other Phone	
Emergency Contact - Name	Relationship	
Address	Phone	
Name of Family Physician	Phone	
Family Medical Hospital	Phone	
Insurance Carrier	Policy/Group No.	

Part I Illness and injuries (check those that apply and give appropriate dates)

Chronic/Recurring Illness	Date	Chronic/Recurring Illness (continued)	Date
<input type="checkbox"/> Ear Infection		<input type="checkbox"/> Bleeding/Clotting Disorders	
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Heart Defect/Disease	
<input type="checkbox"/> Seizures		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Musculoskeletal Disorders	
<input type="checkbox"/> Other _____ Explain and give dates:			

Date of last health examination _____

- Were any complicating medical problems noted in last health examination? Explain.
- Is participant currently under the care of a physician or psychologist? Explain.

Since the last health examination, has the participant had any of the below:

- | | |
|---|---|
| <input type="checkbox"/> A serious injury requiring medical attention? | <input type="checkbox"/> An illness lasting more than 5 days? |
| <input type="checkbox"/> Any prescribed or over-the-counter medication? | <input type="checkbox"/> A surgical operation or fracture? |
| <input type="checkbox"/> Treatment in a hospital or emergency room? | <input type="checkbox"/> Any restrictions concerning physical activities? |
| <input type="checkbox"/> Any exposure to a contagious disease? | <input type="checkbox"/> Other _____ |

If you checked any of the above, please explain and include dates:

Part II Allergies (check all that apply and specify nature of allergic reaction)

- | | | | |
|---------------------------------|--|--|--|
| <input type="checkbox"/> Plants | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Animals | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Pollen | <input type="checkbox"/> Food | <input type="checkbox"/> Medicines/Drugs | <input type="checkbox"/> Other (specify) |

Part III Other Health Conditions (check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Sleep Disease | <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sickle Cell Trait or Disease | <input type="checkbox"/> Special Dietary Regimen | <input type="checkbox"/> Wears Glasses or Contact Lenses |
| <input type="checkbox"/> Other (specify) | | | |

Part IV Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster	Immunizations continued	Year Primary Series Completed	Year of Last Booster
<input type="checkbox"/> DTP			<input type="checkbox"/> Mumps		
<input type="checkbox"/> Diphtheria			<input type="checkbox"/> Rubella (German Measles)		
<input type="checkbox"/> Pertussis (whooping cough)			<input type="checkbox"/> Oral Polio		
<input type="checkbox"/> Tetanus			<input type="checkbox"/> Hib		
<input type="checkbox"/> TD			<input type="checkbox"/> Hepatitis B		
<input type="checkbox"/> Measles			<input type="checkbox"/> Tuberculin Test (most recent)		
<input type="checkbox"/> Other (specify)			<input type="checkbox"/> Other (specify)		

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also indicate any activities to be encouraged or discouraged.

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.

Signature of Parent/Guardian: _____ Date: _____

This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.

Signature of Adult: _____ Date: _____