



## Girl/Adult Health History Form

☐ GIRL MEMBER ☐ ADULT MEMBER

PLEASE PRINT CLEARLY IN INK.

CONTACT INFORMATION	Troop #: _____ or Individual <input type="checkbox"/>	Service Unit: _____	
	First Name: _____	Middle Name: _____	Last Name: _____
	Mailing Address: _____	Apt. #: _____	PO Box: _____
	City: _____	State: _____ Zip: _____	Phone: (    ) _____
	Cell: (    ) _____	E-mail: _____	
	Parent/Guardian(s) Name and address (If different from girl's): (Complete for girl form only) 1. _____		Phone: (    ) _____ Cell: (    ) _____
	Parent/Guardian(s) Name and address (If different from girl's): (Complete for girl form only) 2.. _____		Phone: (    ) _____ Cell: (    ) _____
Custodial Care Information: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Other: _____			

HEALTH INFORMATION	Name of Family Physician: _____		Phone: (    ) _____
	Family Medical/Hospital Insurance Carrier: _____		Policy or Group No: _____
	Family Dental Insurance Carrier: _____		Policy or Group No: _____
	Health Information: Age: _____ Date of birth:    MM    /    DD    /    YY <input type="checkbox"/> Immunizations are up to date.		
	Date of last Tetanus shot:    MM    /    DD    /    YY		
	Date of last health examination: _____ Were there any medical problems at the time? _____		
	Does participant have any physical, mental or psychological conditions requiring medication, treatment, or other special restrictions or considerations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state medication and reason: _____		
	Does participant take any prescribed medications or over the counter drugs on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state medication and reason: _____		
	Is participant restricted or limited from participating in any physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____		
	Please provide a record of past medical treatment, if any, including injures or surgeries: _____		
Participant has the following health conditions/allergies/dietary restrictions (food and medications): <input type="checkbox"/> ADHD <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____ <input type="checkbox"/> Allergies (specify): _____			
Emergency Contact (non-parent): _____			
Relationship: _____		Phone: (    ) _____	Cell: (    ) _____

AUTHORIZATION	<b>PARENT/GUARDIAN AUTHORIZATION</b> This health form is complete and accurate. I know of no reason(s), other than the information indicted on this form, why my daughter/girl should not participate in the prescribed activities except as noted. In the event that my daughter/girl needs medical attention while participating in Girl Scout activities, I authorize the adult in charge to see that my daughter/girl receives routine healthcare, medications, reasonable first aid and to transport my child to a health care facility for emergency services as needed. Signature of parent/guardian: _____ Date: _____
	<b>ADULT MEMBER AUTHORIZATION</b> This health history is complete and accurate. I am able to engage in all prescribed activities except as noted. Signature of adult member: _____ Date: _____

**Parent - please retain a copy for day camp, resident and other overnight camp programs.**

**Troop Leader - please retain for your records**