

Girl OR Adult Health History Form

Name: _____
 DOB: _____ Age: _____
 Address: _____ Phone: () _____
 Parent/Guardian Name: _____
 Home Address: _____ Phone: () _____
 Business Address: _____ Phone: () _____
 Emergency Contact: _____ Relationship: _____
 Emergency Address: _____ Phone: () _____
 Family Physician: _____ Phone: () _____
 Family Insurance Carrier: _____ Policy/Group #: _____
 Member Services Phone Number: _____ Address: _____

Chronic or Recurring Illness (check those that apply and give date of most recent occurrence)

- Ear Infections _____
 - Other(explain) _____
 - Bleeding/Clotting disorder _____
 - Asthma (Emergency Asthma Plan on Back) _____
 - Heart defects/diseases _____
 - Muscular-skeletal disorders _____
 - Hypertension _____
 - Seizures _____
 - Diabetes _____
 - Arthritis _____
 - Sinusitis _____
- Date of last health examination: _____
 Were any complicating medical problems noted in last health exam? Explain: _____

Is participant currently under the care of a physician or psychologist? Please explain.

Please describe conditions and give dates:

Operations or serious injury: _____
 Hospitalizations: _____
 Other diseases/disabilities: _____

Health History (Check those that apply)

Allergies	Diseases	Immunizations	Year of Booster
<input type="checkbox"/> Animals _____	<input type="checkbox"/> Chicken Pox _____	<input type="checkbox"/> D.P.T. _____	_____
<input type="checkbox"/> Pollen _____	<input type="checkbox"/> Measles _____	<input type="checkbox"/> Diphtheria _____	_____
<input type="checkbox"/> Medicine/drugs _____	<input type="checkbox"/> German Measles _____	<input type="checkbox"/> Pertussis _____	_____
<input type="checkbox"/> Plants _____	<input type="checkbox"/> Mumps _____	<input type="checkbox"/> Tetanus _____	_____
<input type="checkbox"/> Hay Fever _____	<input type="checkbox"/> Rheumatic Fever _____	<input type="checkbox"/> Measles _____	_____
<input type="checkbox"/> Food _____	<input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Rubella _____	_____
<input type="checkbox"/> Insect Stings _____	<input type="checkbox"/> Kidney _____	<input type="checkbox"/> Oral Polio _____	_____
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> HBP _____	<input type="checkbox"/> TB Test : Date and Results _____	_____

Suggestions From Parent: My daughter has permission to take or use the following:

- | | | |
|-------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Tylenol/acetaminophen | <input type="checkbox"/> Benadryl/antihistamine | <input type="checkbox"/> Robitussin/expectorant |
| <input type="checkbox"/> Advin/ibuprofen | <input type="checkbox"/> Pepto Bismol | <input type="checkbox"/> Swimmers' Ear/
alcohol-vinegar solution |
| <input type="checkbox"/> Neosporin/topical antibiotic | <input type="checkbox"/> Burn ointment | |
| <input type="checkbox"/> Sudafed/decongestant | <input type="checkbox"/> Tums/antacid | |

Other Health conditions

- | | | | |
|-------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glasses/Contact Lenses | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Heart Impairment | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Other _____ | |

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 restricted.

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN HERE. PLEASE INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental) Medications must be in original containers.

Emergency Asthma Plan:

HEALTH INFORMATION PRIVACY STATEMENT

The Girl/Adult Health Form is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participants or their legal representative. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

AUTHORIZATION

I hereby authorize the doctor, dentist, or such medical agency chosen to render the necessary medical care, first aid and/or medical treatment or service for the health and welfare of my child. Person engaged in helping my child are hereby expressly relieved of any liability for damage that may result from injury incurred while participating in this activity or their good faith effort to render such necessary emergency care and assistance as may be needed.

I also understand that insurance coverage through the GSPB covers \$100.00, after which your personal insurance takes over.

Girl Participant:

I know of no reason(s), other than the information indicated on this form, why my child should not participate in prescribed activities except as noted.

Parent/Guardian signature _____ Date: _____

Girl SS#: _____

Adult Participant:

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

Signature of Adult _____ Date: _____

Adult SS#: _____