

Girl & Adult Health History

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

Girl Scouts of Black Diamond Council follows HIPAA protocol when releasing information contained on this health history form.

Name	Date of Birth	Age
Address	Troop No.	
Parent/Guardian	Phone No.	
Home Address		
Business Address	Phone No.	
In Emergency Notify (Name)	Relationship	
Address	Phone No.	
Name of Family Physician	Phone No.	
Family medical/hospital Insurance carrier	Policy or Group No.	

Part I: Illnesses and Injuries (Check those that apply and give appropriate dates)

Chronic or recurring illness

- | | | | |
|--|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Musculoskeletal Disorders | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other (Specify) _____ | | | |

Date of last health examination _____

Were any complicating medical problems noted in last health examination? _____

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

Since last health exam, has participant had:

- | | |
|--|--|
| A serious injury requiring medical attention? _____ | An illness lasting more than five days? _____ |
| Any prescribed or over-the-counter medication? _____ | A surgical operation or fracture? _____ |
| Treatment in a hospital or emergency room? _____ | Any restrictions concerning physical activities? _____ |
| Any exposure to a contagious disease? _____ | |

Please explain any "Yes" answers to the above questions on a separate sheet. Include dates.

Part II: Allergies

(Check those that apply and specify nature of allergic reaction)

- | | |
|---|--|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Hay Fever _____ |
| <input type="checkbox"/> Pollen _____ | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Medicine _____ | <input type="checkbox"/> Insect Bites _____ |
| <input type="checkbox"/> Plants _____ | <input type="checkbox"/> Other (specify) _____ |

Part III: Other Health Conditions (check those that apply)

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

Part IV: Immunization History

Immunization	Year Primary Series Complete	Year of Last Booster
D.P.T. _____	_____	_____
<i>Diphtheria, Pertussis (Whooping cough)</i>		
Tetanus _____	_____	_____
TB _____	_____	_____
Measles _____	_____	_____
Mumps _____	_____	_____
Rubella _____	_____	_____
<i>German Measles</i>		
Oral Polio _____	_____	_____
HBPV _____	_____	_____
Tuberculin test (most recent result) _____	_____	_____
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.

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 correct and I am able to engage in all prescribed activities except as noted.
Signature of adult _____ Date _____