

# Girl/Adult Health History Form

 GIRL MEMBER    ADULT MEMBER

PLEASE PRINT CLEARLY IN INK.

<b>CONTACT INFORMATION</b>	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: <i>(Complete for girl form only)</i>		Phone: (    ) _____	
	1. _____		Cell: (    ) _____	
Parent/Guardian(s) Name: <i>(Complete for girl form only)</i>		Phone: (    ) _____		
2. _____		Cell: (    ) _____		
Custodial Care Information: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Other: _____				

<b>HEALTH INFORMATION</b>	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: _____ <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? _____
	Has participant had any recent injuries or surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please explain and specify date: _____		
	Does participant take any prescribed medications 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: _____		
	Participant has the following health conditions/allergies (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: (    ) _____	

<b>AUTHORIZATION</b>	<b>PARENT/GUARDIAN AUTHORIZATION</b> This health form is complete and accurate. I know of no reason(s), other than the information indicated 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 reasonable first aid and to transport my child to a health care facility for emergency services as needed.
	Signature of parent/guardian: _____ Date: _____
<b>AUTHORIZATION</b>	<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: _____

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