

Girl/Adult Health History Form

This health history form is to be completed and signed by a girl's caregiver or the adult participant.

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Day Phone _____ Gender _____

Address _____ City _____ State _____ Zip _____

Medical Insurance Carrier _____ Policy/Group # _____

Primary Physician Name _____ Phone _____

Part I: Allergies (specify nature of allergic reaction)

- Animals _____ Hay Fever _____ Medicine/Drugs _____
- Food _____ Insect Stings _____ Plants/Pollen _____
- Other _____

Part II: Illnesses and Diseases – Chronic or Recurring

- Arthritis Diabetes Measles Sinusitis
- Asthma Ear Infection Musculoskeletal Disorder Tuberculosis
- Bleeding/Clotting Disorders Heart Defect/Disease Rheumatic Fever Other _____
- Chicken Pox Hypertension Seizures _____

Part III: Other Health Conditions

- Bed Wetting Fainting Motion Sickness Sleep Disturbances
- Constipation Hearing Impairment Nosebleeds Special Dietary Regimen
- Emotional Disturbances Menstrual Cramps Sickle Cell Trait/Disease Wear Glasses/Contact Lenses

Part IV: Immunization History

- Immunization History is attached. All immunizations are up-to-date.

Permission to give to participant:

- Tylenol/Acetaminophen Tums/Antacid Sudafed/Decongestant Swimmer's Ear or Alcohol/Vinegar Solution
- Benadryl/Antihistamine Advil/Ibuprofen Robitussin/Expectorant None

Participant Statement: I certify that to the best of my knowledge this health history is complete and accurate. I know of no reason(s) other than the information indicated on this form, why I/my daughter should not participate in prescribed activities except noted.

Privacy Statement: All health records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. This information will be held in limited access by the troop leader/healthcare supervisor of the event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate safety and healthcare. I have read the above information and agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Caregiver Authorization: If my child needs medical treatment, I authorize the adult in charge, should it be necessary, to secure the service of a doctor at my expense. I give my permission for her to be attended for care. I am aware that I will be contacted in the case of an emergency.

Caregiver/Adult Participant Signature _____ **Date** _____