Adult Health History and Exam Form

Health History: The more complete information you provide, the better we are able to work with you to ensure you receive the care you need.

Medical Examination: A medical examination is completed for trips lasting more than three nights. The examination is completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months unless a health issue is present. If you have a major health issue, please update this form as your status or issue changes.

Please type or write clearly and legibly.

Name of Adult: (Last, First, Middle Initial)	**Pronouns:**	**Date of Birth:** (XX/XX/XXXX)	**Biological Sex:** ☐M ☐F
Address:		**City:**	**State:** **ZIP:**
Phone:		**Alternate Phone:**	

Emergency Contact Information:

Emergency Contact:	**Relationship:**
Phone:	**Alternate Phone:**

Health Insurance Information *(Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)*

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply (past and present) and explain in detail checked answers:

☐	Diabetes	☐	Eyesight Impairment
☐	Heart Defects/Disease	☐	Hearing Impairment
☐	Asthma or Hay Fever	☐	Speech Impairment
☐	Diseases of the Ears or Ear Infections	☐	Intestinal Disorders/Constipation
☐	Musculoskeletal Disorders	☐	Chicken Pox DATE:_____
☐	Convulsions/Epilepsy/Seizures	☐	Measles DATE:_____
☐	Sinusitis (Sinus Infections)	☐	German Measles DATE:_____
☐	Physical Restrictions	☐	Mumps DATE:_____
☐	Kidney/bladder illness	☐	Rheumatic Fever
☐	Mental/psychological disorder	☐	Tuberculosis
☐	Hypertension/Abnormal Blood Pressure	☐	Kidney Disease
☐	Arthritis	☐	Eating Disorders (Anorexia, Bulimia, etc.)
☐	Nosebleeds	☐	Headaches/Migraines
☐	Hernia	☐	Had surgery or hospitalized in the last 5 years
☐	Menstrual cramps	☐	Currently under doctor's care
☐	Bleeding disorder	☐	Other: _____

Please explain in detail all checked answers marked above (use additional pages as necessary):

Adult Name: _____ **Date:** _____

Allergies: Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Do you suffer from Anaphylaxis? ☐Yes ☐No
*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.
Do you carry an Epipen? ☐Yes ☐No

Do you carry an inhaler? ☐Yes ☐No

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Medications: List any medications currently taken (or have taken in the recent past) including dosage schedule and specific instructions for use.

Medication	Purpose	Dosage Schedule	Specific Instructions
1.			
2.			
3.			
4.			
5.			

Over-the-Counter Medications: Medication(s) I can take in case of accident or injury. Please check all that apply:

- ☐ Tylenol/Acetaminophen
- ☐ Aspirin (fever reducer)
- ☐ Ibuprofen (pain/swelling)
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/expectorant
- ☐ Sudafed/decongestant
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Imodium (anti-diarrhea
- ☐ Dramamine (motion sickness prevention)
- ☐ Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
- ☐ Other: _____ _____
- ☐ Other: _____ _____

Special considerations or notes regarding over-the-counter medications:

**Please be aware for international travel that other over the counter medications may be available in the host country. To be sure you are taking the appropriate medication, please pack enough for your whole trip in your checked bags. Refer to your airline policies for how to pack medications.*

Do you have a Special Medical or Dietary Regiment to be followed? ☐Yes ☐No
If so, please explain: _____

Have you ever had any adverse reactions to general anesthetics? ☐Yes ☐No
If so, please explain: _____

Additional information that is important for other advisors on this trip to know about: _____

_____

Adult Name: _____ **Date:** _____

(This section is to be completed by a physician after the review of health history. Adult must complete all the information in the Health History to the best of their knowledge and sign before meeting with licensed professional.)

Medical Examination

Height: _____ Weight: _____ Pulse Rate: _____ B. P.: ____/____
Sugar: _____ Albumin: _____ Blood Hemoglobin: _____
Hearing: R ___ L ___ Eyes: With Glasses R 20/____ L 20/_____ Without Glasses R 20/_____ L 20/_____
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

_____ Nose	_____ Abdomen	_____ Urinalysis	Other: _____
_____ Throat	_____ Hernia	_____ HGB	_____
_____ Teeth	_____ Genitalia	_____ Appearance/Nutrition	_____
_____ Heart	_____ Skin	_____ General Physical State	_____
_____ Lungs	_____ Musculoskeletal	_____ General Emotional State	_____

Does this applicant have any conditions which might limit activity for this event/travel/assignment; such as chronic disease or other limitations for strenuous activity? Yes No

If yes, please explain: _____

_____

Record of Immunization

	Date Series was Completed	Year of Last Booster		Date Series was Completed	Year of Last Booster
Hep B	_____	_____	Typhoid	_____	_____
DTap/Tdap	_____	_____	Paratyphoid	_____	_____
DT/Td	_____	_____	Cholera	_____	_____
Hib	_____	_____	Yellow Fever	_____	_____
IPV/OPV	_____	_____	Typhus	_____	_____
PCV7	_____	_____	Rocky Mountain Spotted Fever	_____	_____
MMR	_____	_____			
Varicella	_____	_____	Tuberculin Test: Year last given	_____	Result _____
Other:			Not required immunizations, but recommended		
_____	_____	_____	HPV	_____	_____
_____	_____	_____	Rota	_____	_____
_____	_____	_____	MCV4/MPSV4	_____	_____
_____	_____	_____	Hep A	_____	_____
_____	_____	_____	TIV/LAIV	_____	_____

Physician Information

Licensed Physician Name: (Last, First, Middle Initial)	**Phone Number:**		
Address:	**City:**	**St:**	**ZIP:**

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

Signature of Licensed Physician: _____
State License Number: _____ **Date:** _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Adult Health History Exam 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 for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years in the case of treatment. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Adult Health History and Exam Form is complete and accurate.

Signature of Adult Participant: _____ **Date:** _____