# Girl/Adult Health History Form

☐ GIRL MEMBER ☐ ADULT MEMBER *Troop Leader - please retain for your records

**CONTACT INFORMATION**

| Troop #: or Individual ☐ | | |
|---|---|---|
| First Name: | Middle Initial: | Last Name: |
| Address: | Apt. #: | PO Box: |
| City: | State: ZIP: | Phone: |
| Cell: | Email: | |
| Parent/Guardian(s) Name and address *(If different from girl's): (Complete for girl member only)*<br>1. | | Phone:<br>Cell: |
| Parent/Guardian(s) Name and address *(If different from girl's): (Complete for girl member only)*<br>2. | | Phone:<br>Cell: |

**HEALTH INFORMATION**

| Name of Family Physician: | Phone: |
|---|---|
| Family Medical/Hospital Insurance Carrier: | Policy/Group #: |

Health Information: Age:___________ Date of birth: MM DD YY ☐ 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?

Illnesses & Injuries (check all that apply)

☐ Ear Infection ☐ Heart Defect/Disease ☐ Bleeding/Clotting Disorders ☐ Hypertension ☐ Asthma ☐ Diabetes

☐ Muscoskeletal Disorders ☐ Seizures ☐ Other: (specify) ___________________________________________

Allergies (check those that apply and note nature of allergic reaction)

☐ Animals:_______________ ☐ Plants: _______________ ☐ Pollen: _______________ ☐ Hay Fever: _______________

☐ Insect Bites: _______________ ☐ Medicines/Drugs: _______________ ☐ Food: ___________________________

☐ Other: (specify) ___________________________________________

☐ Participant takes medication on a regular basis. Parents, please discuss medication usage and concerns with your troop leader.

Medication:___________________________ Amount: ___________________________ Frequency: ___________________________

Other Health Conditions (check those that apply)

☐ Bed Wetting ☐ Constipation ☐ Menstrual Cramps ☐ Motion Sickness ☐ Nosebleeds ☐ Sleep Disorders ☐ Emotional Disturbances

☐ Hearing Impairment ☐ Sickle Cell Trait or Disease ☐ Fainting ☐ Special Dietary Needs ☐ Wears Glasses or Contact Lenses

☐ Other: (specify) ___________________________________________

Please indicate any information that may be useful to the adult in charge regarding child's/adult's health conditions. Also, indicate any activities that should be restricted: ___________________________________________

In case of emergency, contact:

| Name & Relationship: | Phone: | Cell: |
|---|---|---|
| Name & Relationship: | Phone: | Cell: |

**AUTHORIZATION**

PARENT/GUARDIAN AUTHORIZATION I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities. I will also inform leaders of any changes to this form.

Signature of parent/guardian: ___________________________________________ Date:_______________________

ADULT MEMBER AUTHORIZATION This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.

Signature of adult member: ___________________________________________ Date:_______________________