girl scouts of the colonial coast

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 _____