

## GIRL/ADULT HEALTH HISTORY

For (girl/adult name):		Date of birth:	Present age:	
Social security number (optional):				
Address:		City:	State:	Zip:
Mother's/guardian's name:				
Day phone number: - -		Evening phone number: - -		
Father's/guardian's name:				
Day phone number: - -		Evening phone number: - -		
If parent/guardian cannot be reached in case of an emergency, please call (name):				
Day phone number: - -		Evening phone number: - -		
Relationship to participant:				
Name of physician:			Phone number: - -	
Name of dentist/orthodontist:			Phone number: - -	
Family medical/hospital insurance carrier:				
Policy number:		Group number:		
Date of last health exam:		Were any complicating medical problems noted in exam? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain:				
Is the participant currently under the care of a physician or psychologist? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, for what?				
Is the participant currently taking medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, what and for what?				

Anyone who has a known complicating medical problem or who has had a serious illness or injury or an operation since the last health examination must submit a written statement from a physician giving permission to participate in any activity that normally requires an annual health history or health exam.

**HEALTH HISTORY AND INOCULATION RECORD** (Please check and include dates where appropriate.)

<b>Chronic or Recurring Illnesses</b> (check those that apply):		<b>Other Health Conditions</b> (check those that apply):	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Musculoskeletal disorders	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Bleeding/clotting disorders	<input type="checkbox"/> Seizures	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sickle cell trait or disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other (specify):	<input type="checkbox"/> Emotional disturbances	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Ear infection		<input type="checkbox"/> Fainting	<input type="checkbox"/> Special dietary regimen
<input type="checkbox"/> Heart defect/disease		<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Wears glasses/contact lenses
<input type="checkbox"/> Hypertension		<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Kidney disease		<input type="checkbox"/> Motion sickness	
<b>Allergies</b> (check those that apply and specify nature of allergic reaction):			
<input type="checkbox"/> Animals:		<input type="checkbox"/> Medicines/drugs:	
<input type="checkbox"/> Food:		<input type="checkbox"/> Plants:	
<input type="checkbox"/> Hay fever:		<input type="checkbox"/> Pollen:	
<input type="checkbox"/> Insect stings:		<input type="checkbox"/> Other (specify):	
<b>Immunization History</b>	Years Primary Series Completed	Year of Last Booster	
D.T.P./DTaP			
Td			
MMR (measles/mumps/rubella)			
Chicken pox vaccine (varicella)			
Polio vaccine			
Hib			
Hepatitis B			
Tuberculin test (most recent)			

Are there any physical conditions for which special arrangements need to be made? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, what?
Additional information needed by adult leader about this participant:

\_\_\_\_\_ is physically fit and able to participate in the Girl Scout programs, including summer camp and trips of not more than two nights. I give permission to the physician to order x-rays, routine tests, and treatment for the health of my child in the event that I cannot be reached in an emergency. To the best of my knowledge, the above information is complete and accurate. I agree that videotapes, photographs, and motion picture film in which I/she appear, and/or audio recordings made of my/her voice may be used by Girl Scouts of Virginia Skyline Council and Girl Girl Scouts of the USA, their assigns or successors, in whatever way they desire. Furthermore, I hereby consent that such photographs, films, recordings, and the plates and/or tapes from which they are made shall be their property, and they shall have the right to sell, duplicate, reproduce, and make other uses of such photographs, films, recordings, plates, and tapes as they may desire free and clear of any claim whatever on my part.

My daughter, \_\_\_\_\_, may be given acetaminophen (such as Tylenol). Yes No

Signature of parent/guardian or adult participant: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT: PLEASE SIGN THIS FORM!**