

# Girl Scouts. Adult Health History Record

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION IN BLUE OR BLACK INK.

## PART I: ADULT RECORD

Adult Name	Birth Date	Sex
Address/City/State/Zip		Family E-Mail Address (For GSNC use only)
Cell Phone ( ) ( )	Day Time Telephone ( ) ( )	Evening Phone ( ) ( )

### HEALTH INFORMATION PRIVACY STATEMENT

The Adult Health History Record 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 of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the council, by the participant or their legal representative.

***I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.***

Adult Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PART II: HEALTH INSURANCE INFORMATION

Name of family DENTIST: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Name of family PHYSICIAN: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Family Medical/Hospital INSURANCE CARRIER: \_\_\_\_\_ POLICY/GROUP NUMBER: \_\_\_\_\_

## PART III: ALLERGIES/ILLNESSES/INJURIES

**Allergic Reaction:** (Check those that apply and specify nature of allergic reaction)  Check here for no known allergies

Animals \_\_\_\_\_  Hay Fever \_\_\_\_\_  Medicines/Drugs \_\_\_\_\_  Pollen \_\_\_\_\_

Food \_\_\_\_\_  Insect Stings \_\_\_\_\_  Plants \_\_\_\_\_  Other (specify) \_\_\_\_\_

**Chronic or Recurring Illnesses:** (Check those that apply and give appropriate dates)

Arthritis \_\_\_\_\_  Asthma \_\_\_\_\_  Diabetes \_\_\_\_\_  Dizziness \_\_\_\_\_

Heart Defect/Disease \_\_\_\_\_  Bleeding/Clotting Disorders \_\_\_\_\_  Ear Infection \_\_\_\_\_  Fainting \_\_\_\_\_

Hypertension \_\_\_\_\_  Menstrual Problems \_\_\_\_\_  Musculoskeletal Disorder \_\_\_\_\_  Seizures \_\_\_\_\_

Date of last health examination: \_\_\_\_\_ Were any complicating medical problems noted in last health examination?  NO  YES  
If YES, what? \_\_\_\_\_

**Other health conditions, chronic diseases, or injuries that might impact your participation:** (Explain) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PART IV: MEDICATION

Are you taking any medications?  NO  YES  
If YES, list medication, reason, and possible side effects.

MEDICATION	POSSIBLE SIDE EFFECTS
_____	_____
_____	_____
_____	_____
_____	_____

## PART V: CONSENT TO TREAT

In the event of an emergency, every effort will be made to contact an emergency contact. I hereby give authorization to Girl Scouts of Northern California to seek treatment for myself by a licensed physician pursuant to California Family Code Section 6910 and California Civil Code 25.8. I know of no reason(s), other than the information indicated on this form, why I should not participate in prescribed activities.

Adult Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PART VI: EMERGENCY CONTACT(S)

Name	Relationship	Cell Phone	Day Time Telephone	Evening Phone
1. _____	_____	( ) ( )	( ) ( )	( ) ( )
2. _____	_____	( ) ( )	( ) ( )	( ) ( )
3. _____	_____	( ) ( )	( ) ( )	( ) ( )

Please review this form annually. If there are no changes or just minor adjustments, please mark those, then sign and date the form.

Updated _____	Date _____
Updated _____	Date _____
Updated _____	Date _____
Updated _____	Date _____