girl scouts nation's capital

Adult Health History and Emergency Medical Authorization Form

This form is to be completed annually by adult volunteers and returned to the troop leader and/or troop first-aider prior to attending the first troop meeting. Use additional paper if needed.

Adult's Name: _____ Volunteer Position(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone 1: _____ Phone 2: _____ E-mail: _____

EMERGENCY CONTACTS

Emergency Contact 1: _____ Relationship: _____

Phone 1: _____ Phone 2: _____ E-mail: _____

Emergency Contact 2: _____ Relationship: _____

Phone 1: _____ Phone 2: _____ E-mail: _____

HEALTH INFORMATION

Sex: ☐ Female ☐ Male Optional Information: Date of Birth: _____ Age: _____ Height: _____ Weight: _____

ALLERGIES AND HEALTH CONDITIONS (Check all that apply and provide requested information)

Allergies	Yes	No	Explain "yes" answers. Include the type of allergy (e.g.- "nut allergy" in the food category)
Animals	☐	☐	
Insect Stings	☐	☐	
Plants/Trees	☐	☐	
Food	☐	☐	
Drugs	☐	☐	
Other	☐	☐	

	Condition	Dates		Condition	Dates		Condition	Dates
☐	ADD/ADHD		☐	Epilepsy		☐	Nervous System Disorder	
☐	Arthritis		☐	Fainting		☐	Pregnant	
☐	Asthma		☐	German Measles		☐	Sickle Cell Anemia	
☐	Athletes Foot		☐	Hay Fever		☐	Sinusitis	
☐	Bleeding/Clotting Disorder		☐	Headaches/Migraines		☐	Skeletal Disease/Disorder	
☐	Bronchitis		☐	Hearing		☐	Skin Conditions	
☐	Cancer		☐	Heart Defect/Disease		☐	Sleep Disturbance/Walking	
☐	Chicken Pox		☐	Hypertension		☐	Stomach Upsets	
☐	Colds/Sore Throats		☐	Kidney Disease		☐	Urinary Tract Infections	
☐	Constipation		☐	Mononucleosis		☐	Wear: ☐Contacts ☐Glasses	
☐	Convulsions		☐	Motion Sickness		☐	Other: _____	
☐	Diabetes		☐	Mumps		☐	Other: _____	
☐	Ear Infections		☐	Muscle Disease/Disorder		☐	Other: _____	

Explain any specific needs or accommodations required: _____

Explain any psychiatric counseling or hospitalization: _____

Explain any operations or serious injuries: _____

Explain any disabilities or chronic or recurring illnesses: _____

Explain any activities that are discouraged by your physician: _____

Explain any dietary modifications: _____

Since your last health exam, have you had:	Yes	No	Explain "yes" answers. Provide details and dates.
A serious injury requiring medical attention?	☐	☐	
An illness lasting longer than one week?	☐	☐	
An in-patient hospital or emergency room treatment?	☐	☐	
Restrictions from participating in any activities?	☐	☐	

IMMUNIZATION HISTORY

Are all immunizations current? ☐ Yes ☐ No If not, state reason(s): _____

DTP or DT (Tetanus) Date: _____ Results: _____ Date of Last Health Exam: _____

MEDICATION INFORMATION

Are any prescription medications being taken? ☐ Yes ☐ No Are any of the following used? ☐ Inhaler ☐ Epipen

Name of Medication	Reason for Medication	Dosage	Frequency

MEDICAL CARE AND INSURANCE INFORMATION

Physician: _____ Phone: _____ Dentist/Orthodontist: _____ Phone: _____

Preferred Medical Facility: _____ Address: _____

Insurance Company: _____ Policy #: _____ Date of Last Health Exam: _____

Company Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION FOR MEDICAL CARE

This health history is correct so far as I know. I can engage in all activities except as noted. I hereby give permission to the First-Aider or Adult-In-Charge to provide routine health care if I am unable to do so myself. I consent to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my participation in any activity sponsored by Girl Scouts of the USA, Girl Scouts Nation's Capital, or individual units. Should a medical emergency arise during my participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact my designated alternate at the phone numbers I have given. If it is believed my life or health may be adversely affected by the delay that an attempt to contact my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Signature: _____ Date: _____