Girl Scout Council of the Nation's Capital
4301 Connecticut Avenue, N.W.
Washington, D.C. 20008
PHONE (202)-237-1670 (800)-523-7898
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B230

ADULT HEALTH HISTORY / EMERGENCY MEDICAL AUTHORIZATION FORM

To be filled out by Adult Return Form to: Troop/Group Leader at or before the first meeting. Must be updated yearly or as changes occur.

Adult's Name (first, middle initial, last) _____ Position _____

Home address _____ City _____ State _____ Zip _____

Phones: Day _____ Evening _____ Cell _____

Emergency Contact: _____ Relationship _____

Phones: Day _____ Evening _____ Cell _____

Emergency Contact: _____ Relationship _____

Phones: Day _____ Evening _____ Cell _____

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

Health History: (*Check all that apply and give approximate dates. Use the Continuation Page as necessary*)

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

Wears: ☐ Contacts ☐ Glasses

Allergies:

- ☐ Animals _____
- ☐ Bee/Wasp Stings _____
- ☐ Plants, Ivy/Oak _____
- ☐ Drugs _____
- ☐ Foods _____
- ☐ Other _____

Are there any special needs or accommodations required? If yes, please explain _____

Ever required any psychiatric counseling or hospitalization? If yes, explain _____

Operations or serious injuries _____

Disability or chronic or recurring illness _____

Activities to be encouraged or limited by your physician _____

Dietary modifications _____

Since last health exam have you had: ☐ a serious injury requiring medical attention? _____ ☐ an illness lasting longer than one week? _____

☐ an in-patient hospital treatment or the emergency room? _____ ☐ been restricted from participating in any activities? _____

(Please explain any "YES" answers to the above questions and include dates and/or details. May use the Continuation Page if necessary.)

Immunization History: Are all immunizations up-to-date? ☐ Yes ☐ No If no, please state reason _____

Give dates for person listed above. Complete other information as requested.

DTP or DT (Tetanus) Date: _____ TB test Date: _____ Results: _____ Date of last health exam: _____

Insurance Information: Company _____ Policy Number _____ Policy Holder _____

Company address: _____ City: _____ State _____

Other: Name of Dentist/Orthodontist: _____ Phone _____

Name of Physician _____ Phone _____

Preferred Medical Facility: _____ Location: _____

Medication Information: Any prescribed medication being taken? ☐ No ☐ Yes - ☐ Inhaler ☐ Epipen ☐ Other - what, why, when, and dosage?

_____

IMPORTANT – THIS SECTION MUST BE COMPLETED

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 and administer prescribed medications. 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 GSUSA, GSCNC 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 for trips and camping outside of the normal meeting place.

Signature (in ink) _____ Date _____

*If for religious reasons you cannot sign this form, then submit a legal waiver, which must be signed for attendance/participation.

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ADULT HEALTH HISTORY / EMERGENCY MEDICAL AUTHORIZATION FORM *Continuation Page*

Use this page to enter any information that would not fit on the previous page.