girl scouts
heart of new jersey

Adult Health History Record

Adults must have a current Health History Record on file when traveling with a troop or group. This form must be completed by the adult or their legal guardian. The intent of the form is to give troop/group volunteers and healthcare personnel the background to provide appropriate care. When traveling as a troop/group, one copy should stay with the troop/group, the other should remain with the troop/group's at-home emergency contact.

ADULT PARTICIPANT INFORMATION

Name	Birth Date	Troop #	
Address	City	State	Zip
Legal Guardian Name (if applicable)	Legal Guardian Phone (if applicable)		

EMERGENCY CONTACTS (OTHER THAN LEGAL GUARDIAN LISTED ABOVE)

Name	Phone #	Relationship
Name	Phone #	Relationship

PHYSICIAN AND INSURANCE INFORMATION

Physician Name	Physician Phone #
Insurance Carrier	Policy/Group #
Name of Primary Insured	Primary Insured's Date of Birth

Date of last physical examination

During this examination, were any medical issues noted? ☐ Yes ☐ No

If yes, please explain

HEALTH CONDITIONS

Check all that apply.

☐ ADD/ADHD	☐ Chronic/recurrent illness	☐ Frequent ear infections	☐ Lung disease
☐ Asthma	☐ Diarrhea/constipation	☐ Frequent headaches	☐ Mononucleosis
☐ Anxiety	☐ Diabetes	☐ Head injury	☐ Motion sickness
☐ Autism spectrum	☐ Development/learning disorder	☐ Hearing loss	☐ Pass out/dizziness after exertion
☐ Back or joint pain	☐ Eating disorder	☐ Heart defect/disease	☐ Skin conditions (eczema, rash, etc.)
☐ Bleeding/clotting disorder	☐ Emotional issues/diagnosis	☐ Hypertension	☐ Social issues
☐ Chest pain during/after exercise	☐ Epilepsy/seizures	☐ Insect sting reaction	☐ Vision impairment
☐ Convulsions	☐ Food allergies	☐ Kidney disease	☐ Wears glasses, contacts, protective eyewear
☐ Other (explain)			

ALLERGIES
List any known medication, food, or other allergies. Specify the allergy and reaction.

IMMUNIZATION HISTORY

☐ I certify that all immunizations are up to date, including tetanus.

Date of last tetanus shot:

☐ I choose not to disclose any immunization history. I take full responsibility if illness occurs as a result of attending a Girl Scout event and not providing immunization history. I also understand that I cannot attend events that require immunization records, unless presented at that time.

MEDICATIONS
List all prescription and over-the-counter medications taken on a regular basis. Include the full medication name, dosing information, and reason for taking.

MEETING YOUR NEEDS
Specify any activities you should NOT participate in.

Are there any physical, social, learning, or emotional challenges of which troop/group volunteers should be aware? This information will help volunteers better support you.

HEALTH INFORMATION PRIVACY STATEMENT

This Adult Health History Record may be used solely for your benefit as a participant, to provide adequate participant safety and healthcare. Access to this information will be limited, but copies may be requested from the event sponsor by the participant or their legal representative. This record is effective for one year following the signature date below, after which point the troop/group first aider or leader shall either destroy this form or return to the adult participant for their records.

MEDICAL RELEASE AND WAIVER

☐	The above health history is accurate and complete to the best of my knowledge.
☐	I know of no reasons, other than those indicated on this form, why I cannot participate in general Girl Scout activities.
☐	This completed form may be printed/photocopied.
☐	I give permission for GSHNJ staff or volunteers to release this information to emergency responders, hospital personnel, pharmacy staff, etc. I understand that every effort will be made to contact my legal guardian and/or emergency contacts prior to admission.
☐	I hereby give permission to medical personnel selected by GSHNJ to provide necessary healthcare; to administer medication; to order X-rays, tests, treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation for me.
☐	I hereby give permission to the physician to secure and administer treatment, including hospitalization, and to order injections and/or anesthesia and/or surgery if deemed medically necessary.

In witness whereof, this release and waiver has been carefully read and the contents of this document are understood by the undersigned. This release and waiver shall be effective for one year following the Adult Health History Record completion date. The undersigned freely executes this release and waiver on the date shown below.

Adult Participant Name:	
Adult Participant Signature:	
Legal Guardian Name (if applicable):	
Legal Guardian Signature (if applicable):	
Date:	