Adult Health History Record

Adults are required to have a current Health History Record on file when traveling with a troop/group. One copy should travel with the troop/group, the other should remain with the at-home emergency contact.

Name: | Birth Date: | SU# | Troop #
Address: | City: | State: | Zip:
Phone #: | Email Address:

EMERGENCY CONTACTS

Name:	Phone #:	Relation to Adult:
Name:	Phone #:	Relation to Adult:

Name of Physician: | Physician Phone #:
Name of Dentist: | Dentist Phone #:
Family Insurance Carrier: | Policy/Group #:
Name of Primary Insured:

PART I: ILLNESS OR INJURIES

Asthma	Bleeding/Clotting Disorder	Bones/Joints Conditions	Convulsions	Diabetes	Ear Infection
Epilepsy	Hypertension	Kidney Disease	Lung Disease	Other:	

IN THE PAST 5 YEARS HAVE YOU:

Had a serious injury requiring medical attention?	Had a fracture?	Taken any medication on a regular basis?
Been treated in the emergency room of a hospital?	Had an illness lasting more than two weeks?	Had surgery of any kind?
Been admitted to a hospital for treatment?	Been restricted from participating in any physical activity for an extended period?	

If yes, please explain:

PART II: ALLERGIES (check all that apply and list treatment)

Animals/Insects	Food
Plants	Seasonal Allergies
Medicine/Drugs	Other

PART III: OTHER HEALTH CONDITIONS (check all that apply)

ADD	Sleep Disturbances	Hearing Impairment	Vision Impairment	Abnormal blood pressure	Emotional Disturbances
ADHD	Dental Braces	Hearing Aid	Glasses/Contacts	Sickle Cell	Nosebleeds
Arthritis	Motion Sickness	Fainting	Obesity	Special Diet	Down's Syndrome

Other:

PART IV: IMMUNIZATION HISTORY

IMMUNIZATION	DATE PRIMARY SERIES COMPLETED	DATE OF LAST BOOSTER
COVID		
Tdap (Tetanus/Diptheria/Pertussis)		
Td (Tetanus/Diptheria)		
MMR (Measles/Mumps/Rubella)		
Chicken Pox		
Oral Polio		
HbPV (Haemophilus b Polysaccharide)		
Tuberculin	Date of Last Test:	Result:
Other:		

I choose not to disclose any immunization history and therefore take full responsibility if any 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. By checking this box and signing below, I demonstrate that I understand my risk and responsibility.

ACTIVITY RESTRICTIONS:

EMERGENCY MEDICAL CARE Medical Release and Waiver

I hereby give permission to the medical personnel selected by GSHNJ to provide routine health care; to administer medication; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. In the event that I cannot be reached in an emergency, I hereby give permission to the physician to secure and administer treatment, including hospitalization, and to order injections and/or anesthesia and/or surgery.

HEALTH INFORMATION PRIVACY STATEMENT

All Adult Health History 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 a specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The form will be retained by GSHNJ or GSUSA until it is destroyed. All records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the event sponsor by the participant or their legal representative. I have read the above procedures for handling the Health Records information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

I know of no reasons, other than those indicated on this form, why I should not participate in general Girl Scout activities.

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 all activities throughout the membership year of the completion date (October 1-September 30). The undersigned freely executes this release and waiver on the date shown below.

Printed Name: Signature: Date: