



Girl/Adult Health History Form

GIRL MEMBER ADULT MEMBER

PLEASE PRINT CLEARLY IN INK.

CONTACT INFORMATION	Troop #: _____ or Individual <input type="checkbox"/>	Service Unit: _____	
	First Name: _____	Middle Name: _____	Last Name: _____
	Mailing Address: _____	Apt. #: _____	PO Box: _____
	City: _____	State: _____ Zip: _____	Phone: () _____
	Cell: () _____	E-mail: _____	
	Parent/Guardian(s) Name and address (If different from girl's): (Complete for girl form only)		Phone: () _____
	1. _____		Cell: () _____
Parent/Guardian(s) Name and address (If different from girl's): (Complete for girl form only)		Phone: () _____	
2. _____		Cell: () _____	
Custodial Care Information: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Other: _____			

HEALTH INFORMATION	Name of Family Physician: _____	Phone: () _____
	Family Medical/Hospital Insurance Carrier: _____	Policy or Group No: _____
	Family Dental Insurance Carrier: _____	Policy or Group No: _____
	Health Information: Age: _____ Date of birth: MM / DD / YY <input type="checkbox"/> Immunizations are up to date.	
	Date of last Tetanus shot: MM / DD / YY	
	Date of last health examination: _____	Were there any medical problems at the time? _____
	Does participant have any physical, mental or psychological conditions requiring medication, treatment, or other special restrictions or considerations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state medication and reason: _____	
	Does participant take any prescribed medications or over-the-counter drugs on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state medication and reason: _____	
	Is participant restricted or limited from participating in any physical activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____	
	Please provide a record of past medical treatment, if any, including injuries or surgeries: _____	
Participant has the following health conditions/allergies/dietary restrictions (food and medications): <input type="checkbox"/> ADHD <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____ <input type="checkbox"/> Allergies (specify): _____		
Emergency Contact (non-parent): _____		
Relationship: _____	Phone: () _____	Cell: () _____

AUTHORIZATION	PARENT/GUARDIAN AUTHORIZATION This health form is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter/girl should not participate in the prescribed activities except as noted. In the event that my daughter/girl needs medical attention while participating in Girl Scout activities, I authorize the adult in charge to see that my daughter/girl receives routine healthcare, medications, reasonable first aid and to transport my child to a health care facility for emergency services as needed.
	Signature of parent/guardian: _____ Date: _____
	ADULT MEMBER AUTHORIZATION This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.
	Signature of adult member: _____ Date: _____

**Parent - please retain a copy for day camp, resident and other overnight camp programs.
Troop Leader - please retain for your records**