Girl Scouts. Adult Health History Record with Physical

Required for all Camp Tall Trees overnight volunteers.

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION IN BLUE OR BLACK INK.

PART I: ADULT RECORD

Adult Name | Birth Date | Sex

Address/City/State/Zip | Family E-Mail Address *(For GSNC use only)*

Cell Phone ( ) | Day Time Telephone ( ) | Evening Phone ( )

HEALTH INFORMATION PRIVACY STATEMENT

The Adult Health History Record is for health care concerns at the specified event only. All 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 the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the council, by the participant or their legal representative.

I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Adult Participant Signature: Date:

PART II: HEALTH INSURANCE INFORMATION

Name of family DENTIST:_____Telephone: ( )_____

Name of family PHYSICIAN:_____Telephone: ( )_____

Family Medical/Hospital INSURANCE CARRIER: _____POLICY/GROUP NUMBER: _____

PART III: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) **❒ Check here for no known allergies**

❒Animals _____ ❒Hay Fever _____ ❒Medicines/Drugs _____ ❒Pollen_____

❒Food_____ ❒Insect Stings _____ ❒Plants _____ ❒Other (specify) _____

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

❒Arthritis_____ ❒Asthma _____ ❒Diabetes _____ ❒Dizziness _____

❒Heart Defect/Disease_____ ❒Bleeding/Clotting Disorders___ ❒Ear Infection _____ ❒Fainting _____

❒Hypertension _____ ❒Menstrual Problems_____ ❒Musculoskeletal Disorder _____ ❒Seizures_____

Date of last health examination: _____ Were any complicating medical problems noted in last health examination? ❒NO ❒YES

If YES, what? _____

Other health conditions, chronic diseases, or injuries that might impact your participation: (Explain) _____

_____

_____

PART IV: MEDICATION

Are you taking any medications? ❒ NO ❒ YES

If YES, list medication, reason, and possible side effects.

MEDICATION	POSSIBLE SIDE EFFECTS

PART V: CONSENT TO TREAT

In the event of an emergency, every effort will be made to contact an emergency contact. I hereby give authorization to Girl Scouts of Northern California to seek treatment for myself by a licensed physician pursuant to California Family Code Section 69I0 and California Civil Code 25.8. I know of no reason(s), other than the information indicated on this form, why I should not participate in prescribed activities.

Adult Participant Signature: Date:

PART VI: EMERGENCY CONTACT(S)

Name	Relationship	Cell Phone	Day Time Telephone	Evening Phone
1.		( )	( )	( )
2.		( )	( )	( )
3.		( )	( )	( )

Please review this form annually. If there are no changes or just minor adjustments, please mark those, then sign and date the form.

Updated _____ Date _____

Updated _____ Date _____

Updated _____ Date _____

Updated _____ Date _____

PART VI: RECORD OF HEALTH EXAMINATION

To be completed within 24 months within completion of the trip or camp attendance by a
LICENSED PHYSICIAN – MD, PHYSICIAN'S ASSISTANT OR
A NURSE PRACTITIONER ACTING UNDER THE SUPERVISION OF A LICENSED MD

I have examined the above applicant within the past 24 months. DATE EXAMINED _____

In my opinion, the above applicant's condition ❑ DOES ❑ DOES NOT preclude her participation in an active program. Activities to be limited:_____

The applicant is under the care of a physician for the following conditions: _____

_____

Current treatment (including medications): _____

_____

_____

Height_____Weight_____ Blood Pressure _____

Name of Physician_____

Signature of Physician _____

Phone (_____) _____

Date Signed _____

Doctor's Office Stamp or Address