girl scouts of northern california

October 1, 20_____ to September 30, 20_______

Adult Health History Form with Physical

Please download and save this form before entering the information. You may also choose to print and complete the form manually. Kindly print clearly.

Name: ______________________ Birthdate ______________ Gender: ______________

Address: ______________________________ City/State: ______________ Zip: ________

Email: ____

Mobile: ______________ Day Time Phone: ______________ Evening Phone: ______________

HEALTH INFORMATION PRIVACY STATEMENT
The Adult Health History Form 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(s) in order to provide adequate participant safety and health care. The health history record will be retained by Girl Scouts of Northern California, the sponsoring 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 event sponsor by the participant or their legal representative.

HEALTH INSURANCE INFORMATION

Name of family DENTIST: ______________________________ Phone: ______________

Name of family PHYSICIAN: ______________________________ Phone: ______________

Hospital Insurance Information:

Name of Carrier: ______________________________ Policy #: ______________

Insured's Name: ______________________ Member ID#: ______________________

Insured's Employer (if insurance is through work): ______________________ Phone: ______________

Others who could be contacted to authorize treatments:

Name: ______________________ Relationship to Adult: ____________ Phone: ______________

Name: ______________________ Relationship to Adult: ____________ Phone: ______________

Dietary Needs/Restrictions:

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PART A Allergies	**Check those that apply. Specify cause and nature of reactions (i.e. Penicillin causes hives.)** Animals ____________ Plants/Trees ________ Insect Sting ________ Hayfever ____________ Pollen ________ Other: ______________________
	Food: ______________________
	Medicine/Drugs:
	In case of an allergic reaction, respond by ______________________

PART B Medical History	Check those that apply.		
	ADD/ADHD	Ear Infection	Mumps
	Arthritis	Eating Disorders	Muscle Disease/Disorder
	Asthma	Emotional Disturbances	Nervous System Disorder
	Anxiety	Epilepsy	Nosebleeds
	Athletes Foot	EYES: Contact Lenses	Orthodontic Appliances
	Behavioral Changes	EYES: Glasses	Physical Disabilities
	Bet Wetting	Fainting	Runny Nose
	Bipolar Disorder	German Measles	Seizures
	Bleeding/Clotting Disorder	Hay Fever	Sickle Cell Trait or Disease
	Bronchitis	Headaches, frequent	Sinusitis
	Chicken Pox	Hearing Impairment	Skeletal Disease/Disorder
	Concussion	Heart Defect/Disease	Skin Conditions
	Constipation	Hepatitis A/B/C	Sleep Disturbance
	Convulsions	Hypertension	Sleep Walking
	Cough	Kidney Disease	Sore Throat
	COVID-19	Measles	Special Dietary Regiment
	Depression	Menstrual Complications	Stomach Upsets
	Diabetes	Migraines	Urinary Tract Infection
	Diarrhea	Mononucleosis	Visual Impairments
	Down's Syndrome	Motion Sickness	
	Other:		

Please explain. Indicate any information in relation to any of the health conditions chosen in Part B. Indicate any activity to be encouraged or restricted.

Dietary Needs/Restrictions:

PART C Immunization & Disease History	REQUIRED: Please complete			
	Immunization	Year Primary Series Completed	Year of Last Booster	Has had Disease YES or NO
	Chicken Pox			
	COVID-19			
	D.T.P.			
	Diphtheria			
	Hepatitis B			
	Hib *Haemophilus influenzae B*			
	Measles			
	Mumps			
	Oral Polio			
	Pertussis (whooping cough)			
	Rubella (German Measles)			
	Td (tetanus/diptheria)			
	Tetanus			
	Tuberculin Test Result (most recent)			
	Other:			

All my vaccinations are up to date

PART D Medications	**Listed are all prescribed medications(s) that I routinely take.** (Attach is a separate list, if necessary.)		
	Medication	Dosage	How often?
Please initial below if applicable			
↓	**I will self-administer the follwing medication(s)**		
*	Bronchial Inhaler		
*	Diabetic Medication		
*	Epi-pen		
*	Other		

Over-The-Counter Medication(s):
Over-the-counter medications will be used to treat routine illness per treatment protocols. Acetaminophen is used in place of aspirin.

She can have   Pain medications   Cough syrup   Antibiotic ointment   Fever reducer

Digestive relief   Other: ______________________________

I CANNOT have:

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Transportation Release: I authorize transportation by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for my benefit, safety, and well-being. It is my expressed intention to hold Girl Scouts of Northern California harmless for any and all injuries, death, or damages arising from or in any way related to such transportation.

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. I hereby give permission to the licensed physician to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery should my medical emergency require this treatment.

The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to troop/group leaders, drivers, medical personnel, etc. who have a need to know.

Authorization:

- To my best knowledge this health history is correct.
- I am able to engage in all planned trip activities except as noted by the examining physician.
- I acknowledge that an inherent risk of exposure to COVID-19 exists for any in-person activity, including meetings, activities, events, and trips.
- I am voluntarily assuming all risks related to exposure to COVID-19 and agree not to hold Girl Scouts of Northern California, or any of its directors, employees, agents or volunteers, liable for any illness or injury.

______________________________   ______________________________
Participant Signature   **Date**

______________________________   ______________________________   ______________________________
Print Name of Participant   **Phone**   **Email Address:**

Record of Health Examination: To be completed within 24 months of event attendance by a licensed physician – MD. Physician's Assistant or Nurse Practitioner acting under the supervision of a licensed MD.

I have examined the above applicant within the past 24 months. Date of exam: ____
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 condition: ____

Current treatment (including medication): ____

Height: ________ Weight: _______ Blood Pressure: _______

Name of Physician: ____

Signature of Physician: ____

Doctor's Office Address: ____

Phone: ____

Date Signed: ____