

GIRL AND ADULT HEALTH HISTORY

Begin Year: _____

Use: This health history is to be completed and signed by parent/guardian of girl or by adult members themselves.

Troops: Please keep this in a secure and confidential manner. Keep with troop during activities.

Member Name _____	Date of Birth _____	Age _____
Parent/Guradian _____	Troop # _____	
Home Address _____	Home Phone _____	
City, State, Zip _____		
Work Address _____	Home Phone _____	
City, State, Zip _____		

Emergency Contact	Relationship	Phone
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Family Physician _____	Phone _____
Family Hospital _____	Phone _____
Insurance Carrier _____	Policy/group # _____

ILLNESS AND INJURY

(Explain all "YES" answers on back of sheet)

Is member currently:	under the care of a physician or psychologist?	YES	NO
	taking any medications (prescribed or over the counter)?	YES	NO
	under any restrictions concerning physical activity?	YES	NO
	up to date on immunizations?	YES	NO

Date of last Tetanus shot? _____

HEALTH CONSIDERATIONS

<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Fainting	<input type="checkbox"/> Heart Disease/Defect
<input type="checkbox"/> Bleeding/Clotting disorder	<input type="checkbox"/> Glasses/contact lenses	<input type="checkbox"/> Musculoskeletal disorders
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Menstrual Cycle began	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Sickle Cell Trait	<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Asthma	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Emotional disturbances	<input type="checkbox"/> Nosebleeds	
<input type="checkbox"/> Special dietary needs	<input type="checkbox"/> Constipation	

Please explain any checked items. Include dates/current treatment (use back of sheet if necessary)

ALLERGIES

<input type="checkbox"/> Animals	<input type="checkbox"/> Food	<input type="checkbox"/> Plants
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Medicines	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Pollen	<input type="checkbox"/> Insect stings	

Please explain any items that are checked. Indicate specific items of allergy, nature of reactions, and treatment. Include any other information useful to the adult in charge. Also, indicate any activities to be encouraged or restricted.

Use back of sheet if necessary

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter/myslef should not participate in activities except as noted.

Signature of parent/guradian for girl or adult member	Date

I hereby give consent for emergency medical treatment to be given to my daughter in the event that neither myself no the emergency contacts are available to authorize such treatment.

Signature of parent/guradian for girl or adult member	Date



Member Name: _____

Re-Verification Parent/guardian for girl or adult member agrees that the previous information is up to date.

Year: _____	Signature _____	Date _____
Year: _____	Signature _____	Date _____
Year: _____	Signature _____	Date _____

Include exented notes from front here along with updates and changes.