

Girl Scouts Diamonds of Arkansas, Oklahoma, and Texas

Girl and Adult Health History Record

This health history is to be completed and signed by girl's parent/guardian or adult member.

Name _____ Age _____ Date of Birth _____
Activity/Event _____ Troop/Group# _____
Address _____ City _____ Zip _____
Parent/Guardian _____ Phone () _____
Business Address _____ Phone () _____
In case of emergency notify (other than parent or guardian):
Name _____ Phone () _____
Address _____ Relationship _____
Physicians Name _____ Phone () _____
Medical Insurance Carrier _____ Policy Number _____

Part 1: Please list all illnesses and injuries with dates if possible:

Date of last health examination _____ reason for examination _____
Is participant currently under the care of a physician? _____ Please list any medications
participant is taking and frequency? _____

Since last health examination has participant required any medical attention? _____
Any exposure to a contagious disease? _____
Does participant have any restrictions concerning physical activity? _____

Part 2: Allergies (check all that apply and specify nature of allergic reactions)

Animals _____ Hay Fever _____ Pollen _____ Food _____ Plants _____ Insect Stings
Medicines/drugs (specify) _____ Other (specify) _____

Part 3: Other Health Conditions (please check all that apply)

Nosebleeds _____ Sleep disturbances _____ Kidney trouble _____ Fainting _____
Constipation _____ Menstrual cramps _____ Hearing impairment _____ Emotional
disturbances _____ Glasses or contact lenses _____ Special dietary regimen (please
specify) _____ Other (please specify) _____

Part 4: Immunization History

Immunization	Date
DPT	_____
TD	_____
MMR	_____
Polio	_____
Hib	_____
Hepatitis B(series of 3)	_____
Other	_____

In the event of an emergency, every effort will be made to contact a parent or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts to seek treatment for my child by a licensed physician.

Parent/Guardian Signature _____

Date _____

This health history is correct and the member is able to engage in all prescribed activities as noted.

Signature of Adult Member/Parent or Guardian (for minors) _____

_____ Date _____