



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 \_\_\_\_\_

