Adult Health History

Name ____

☐Male ☐Female Birth date _____________________________________

Phone Home___________________________ Work ___________________________Cell _____________________

Address _______________________________City ________________________ State _______ Zip _____________

In Case of Emergency Notify:

Name ____Phone (H)_______________ (W) _________________

Address _______________________________ City _______________________ State ________ Zip ____________

Date of Last Health Exam _____________

Physician's Name _______________________________ ___ Physician's Phone _____________________________

Date of Last Health Exam _____________Were there any complicating medical problems noted? ________________

If swimming, horseback riding or strenuous activities are to be part of the program, a statement from a licensed physician as to your general condition and your ability to participate in all program activities must accompany this form.

HEALTH HISTORY:

Please check and give dates if you have any of the following conditions:

☐ Ear Infections ☐ Hypertension ☐ German Measles ☐ Convulsions ☐ Musculoskeletal Disorder ☐ Mumps
☐ Diabetes ☐ Plant/Pollen Allergies ☐ Asthma ☐ Heart Defect/Disease ☐ Insect Sting Allergy ☐ Chicken Pox
☐ Bleeding/Clotting Disorder ☐Drug Allergies (specify) ☐ Other ☐ Hepatitis B Carrier ☐ Other Allergies (specify)

Details of above conditions ____
Date of last Tetanus booster ____________________

Other health conditions: (Check all that apply)

☐ Frequent constipation ☐ Special dietary regimen ☐ Hearing impairment☐ Menstrual cramps
☐ Emotional disturbances ☐ Wear glasses☐ Sleep disturbances ☐ Fainting ☐ Wears contact lenses

Please explain items checked ____

Are there other health concerns the Health Supervisor/Troop Leader should be aware of? ☐ Yes ☐ No If yes, explain
Are you currently under the care of a physician or psychologist? ☐ Yes ☐ No
Are you currently taking any medication? ☐ No ☐Yes If yes, please list

Since your last health examination, have you had: (Give dates and explain)

☐ A serious injury requiring medical attention? ☐ Treatment in a hospital or emergency room?
☐ An illness lasting more than five (5) days? ☐ A surgical operation or fracture?
☐ Any restrictions concerning physical activities?

Do you consider yourself to be in good health and able to participate in normal program activities? ☐ Yes ☐ No
If no, please explain ____

Dietary considerations ____ If I

am exposed to contagious disease in the three weeks prior to event/program, I will notify the director. To the best of my knowledge, this health history is correct.
In case of emergency, I give my permission to persons representing Girl Scouts DAOT to see that I receive appropriate emergency medical or surgical treatment, and/ or hospitalization if necessary. It is understood that every effort will be made to reach the person named above.

Signature ____Date ______________________________