

ADULT HEALTH HISTORY

Name _____ Male Female Phone (H) _____ (W) _____ Birthdate _____
 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 _____
 Were there any complicating medical problems noted? _____

HEALTH HISTORY:

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Ear Infections _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> German Measles _____ |
| <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> Musculoskeletal Disorder _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Plant/Pollen Allergies _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Heart Defect/Disease _____ | <input type="checkbox"/> Insect Sting Allergy _____ | <input type="checkbox"/> Chicken Pox _____ |
| <input type="checkbox"/> Bleeding/Clotting Disorder _____ | <input type="checkbox"/> Drug Allergies (specify) _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis B Carrier _____ | <input type="checkbox"/> Other Allergies (specify) _____ | |

Date of last Tetanus booster _____

Details of above conditions _____

Other health conditions: (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent constipation | <input type="checkbox"/> Special dietary regimen | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Emotional disturbances | <input type="checkbox"/> Wear glasses |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Fainting | <input type="checkbox"/> Wears contact lenses |

Please explain items checked: _____

Are there other health concerns the 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 CAROLINAS PEAKS TO PIEDMONT 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 _____