Adult Health History Record

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION IN BLUE OR BLACK INK.

PART I: ADULT RECORD

Adult Name | Birth Date | Sex

Address/City/State/Zip | Family E-Mail Address *(For GSNC use only)*

Cell Phone ( ) | Day Time Telephone ( ) | Evening Phone ( )

HEALTH INFORMATION PRIVACY STATEMENT

The Adult Health History Record is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the council, by the participant or their legal representative.

I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Adult Participant Signature: Date:

PART II: HEALTH INSURANCE INFORMATION

Name of family DENTIST:_____ Telephone: ( )_____

Name of family PHYSICIAN:_____ Telephone: ( )_____

Family Medical/Hospital INSURANCE CARRIER:_____ POLICY/GROUP NUMBER: _____

PART III: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) **❒ Check here for no known allergies**

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

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

❒Arthritis _____ ❒Asthma _____ ❒Diabetes _____ ❒Dizziness _____
❒Heart Defect/Disease _____ ❒Bleeding/Clotting Disorders ___ ❒Ear Infection _____ ❒Fainting _____
❒Hypertension_____ ❒Menstrual Problems _____ ❒Musculoskeletal Disorder _____ ❒Seizures_____

Date of last health examination: _____ Were any complicating medical problems noted in last health examination? ❒NO ❒YES
If YES, what? _____

Other health conditions, chronic diseases, or injuries that might impact your participation: (Explain)_____

_____

_____

PART IV: MEDICATION

Are you taking any medications? ❒ NO ❒ YES

If YES, list medication, reason, and possible side effects.

MEDICATION	POSSIBLE SIDE EFFECTS

PART V: CONSENT TO TREAT

In the event of an emergency, every effort will be made to contact an emergency contact. I hereby give authorization to Girl Scouts of Northern California to seek treatment for myself by a licensed physician pursuant to California Family Code Section 69I0 and California Civil Code 25.8. I know of no reason(s), other than the information indicated on this form, why I should not participate in prescribed activities.

Adult Participant Signature: Date:

PART VI: EMERGENCY CONTACT(S)

Name	Relationship	Cell Phone	Day Time Telephone	Evening Phone
1.		( )	( )	( )
2.		( )	( )	( )
3.		( )	( )	( )

Please review this form annually. If there are no changes or just minor adjustments, please mark those, then sign and date the form.

Updated_____ Date_____
Updated_____ Date_____
Updated_____ Date_____
Updated_____ Date_____