girl scouts of northern california

Girl Scouts of Northern California with offices in: Chico, Eureka, Alameda, Red Bluff, Redding, San Jose, Santa Rosa, & Ukiah
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Adult Health History with Physical

(Use for trips lasting 3 or more nights or for strenuous activities)

Part 1: Adult information

Adult Name: Birth Date: ☐ Female ☐ Male

Address/City/Zip: Email:

Day Phone: Evening Phone: Cell 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 2: Insurance Information

Name of Dentist: Phone #:

Name of Doctor: Phone #:

Insurance Carrier Name: Policy/Group Number:

Part 3: Allergies/Illnesses/Injuries

Allergic Reactions: (Check those that Apply and specify nature of the 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? ☐ Yes ☐ No

If yes please explain:

Other health conditions or injuries that might impact your participation?

Part 4: Medication

Are you taking any medications? ☐ Yes ☐ No

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

Medication	Possible Side Effects

Part 5: Consent to Treat

In the event of an emergency, every effort will be made to contact an emergency contact. I hereby give authorization to the Girl Scouts of Northern California to seek treatment for myself by a licensed physician pursuant to California Family Code Section 6910 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 6: Emergency Contact(s)

Name	Relationship	Cell Phone	Day Phone	Evening Phone

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

Signed:	Date:
Signed:	Date:
Signed:	Date:
Signed:	Date:
Signed:	Date:

Part 7: Record of Health Exam

To be completed within 24 months of completion of the trip or camp attendance by a Licensed Physician – MD, Physician's Assistant or Nurse Practitioner acting under the supervision of a licensed MD

I have examined the above applicant within the past 24 months. Date Examined:

In my opinion, the above applicant's condition ☐ DOES ☐ DOES NOT preclude her participation in an active program

Activities to be limited:

The applicant is under the care of a physician for the following condition:

Current Treatment (including medication):

Height: Weight: Blood Pressure:

Doctor's Office Stamp or Address

Name of Physician:

Signature of Physician:

Phone: Date Signed:

If you need medical or dental attention, you must give permission. For those times when it will be hard to contact your family, you can give permission to other adults. They can then act for you in permitting medical or dental care for yourself when family is not available. This is a legal document. With it you may appoint other adults to act for you. This document will be kept with the responsible adult at the camp or event.
You and an adult of your family (spouse, parent, child over the age of 18) must sign the authorization form, which MUST be notarized.

I, Name **and named family member,** Address **do hereby appoint:** Phone

1.

2.

3.

4.

To act on by behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named adult during the period from (Date of travel).
This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

Signature of adult participant: Typed name of adult participant:

Signature of named family member: Typed name of family member:

In the state of: County of: On this date of:

this month: this year: before me personally appeared, and

Proved to me on the basis of satisfactory evidence to be the individual, or individuals described in and who executed the within and forgoing instrument, and acknowledged that he/she/they signed the same as his/her/their free and voluntary act and deed, for the uses and purposes therein mentioned.

Notary Seal

Given under my hand and official seal this day of (year)

Notary Signature:

Notary Printed Name:

Notary Public in and for the State of:

My appointment expires on: