girl scouts of northern california

October 1, 20_____ to September 30, 20_____

Adult Health History Form with Physical

Please download and save this form before entering the information. You may also choose to print and complete the form manually. Kindly print clearly.

Name: _____ Birthdate _____ Gender: _____

Address: _____ City/State: _____ Zip: _____

Email: _____

Mobile: _____ Day Time Phone: _____ Evening Phone: _____

HEALTH INFORMATION PRIVACY STATEMENT

The Adult Health History Form 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(s) in order to provide adequate participant safety and health care. The health history record will be retained by Girl Scouts of Northern California, the sponsoring 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 event sponsor by the participant or their legal representative.

HEALTH INSURANCE INFORMATION

Name of family DENTIST: _____ Phone: _____

Name of family PHYSICIAN: _____ Phone: _____

Hospital Insurance Information:

Name of Carrier: _____ Policy #: _____

Insured's Name: _____ Member ID#: _____

Insured's Employer (if insurance is through work): _____ Phone: _____

Others who could be contacted to authorize treatments:

Name: _____ Relationship to Adult: _____ Phone: _____

Name: _____ Relationship to Adult: _____ Phone: _____

Dietary Needs/Restrictions:

_____

_____

_____

PART A Allergies	**Check those that apply. Specify cause and nature of reactions (e.g. Penicillin causes hives)** ☐Animals _____ ☐Plants/Trees _____ ☐Insect Sting _____ ☐Hayfever _____ ☐Pollen _____ ☐Other: _____
	☐Food: _____
	☐Medicine/Drugs:
	In case of an allergic reaction, respond by _____

PART B Medical History	**Check those that apply.**		
	☐ ADD/ADHD	☐ Ear Infection	☐ Mumps
	☐ Arthritis	☐ Eating Disorders	☐ Muscle Disease/Disorder
	☐ Asthma	☐ Emotional Disturbances	☐ Nervous System Disorder
	☐ Anxiety	☐ Epilepsy	☐ Nosebleeds
	☐ Athletes Foot	☐ EYES: Contact Lenses	☐ Orthodontic Appliances
	☐ Behavioral Changes	☐ EYES: Glasses	☐ Physical Disabilities
	☐ Bed Wetting	☐ Fainting	☐ Runny Nose
	☐ Bipolar Disorder	☐ German Measles	☐ Seizures
	☐ Bleeding/Clotting Disorder	☐ Hay Fever	☐ Sickle Cell Trait or Disease
	☐ Bronchitis	☐ Headaches, frequent	☐ Sinusitis
	☐ Chicken Pox	☐ Hearing Impairment	☐ Skeletal Disease/Disorder
	☐ Concussion	☐ Heart Defect/Disease	☐ Skin Conditions
	☐ Constipation	☐ Hepatitis A/B/C	☐ Sleep Disturbance
	☐ Convulsions	☐ Hypertension	☐ Sleep Walking
	☐ Cough	☐ Kidney Disease	☐ Sore Throat
	☐ COVID-19	☐ Measles	☐ Special Dietary Regiment
	☐ Depression	☐ Menstrual Complications	☐ Stomach Upsets
	☐ Diabetes	☐ Migraines	☐ Urinary Tract Infection
	☐ Diarrhea	☐ Mononucleosis	☐ Visual Impairments
	☐ Down's Syndrome	☐ Motion Sickness	
	☐ Other:		

Please explain. Indicate any information in relation to any of the health conditions chosen in Part B. Indicate any activity to be encouraged or restricted.

Dietary Needs/Restrictions:

PART C Immunization & Disease History	**REQUIRED:** Please complete			
	Immunization	Year Primary Series Completed	Year of Last Booster	Has had Disease YES or NO
	Chicken Pox			
	COVID-19			
	D.T.P.			
	Diphtheria			
	Hepatitis B			
	Hib *Haemophilus influenzae B*			
	Measles			
	Mumps			
	Oral Polio			
	Pertussis (whooping cough)			
	Rubella (German Measles)			
	Td (tetanus/diptheria)			
	Tetanus			
	Tuberculin Test Result (most recent)			
	Other:			

☐ All my vaccinations are up to date

PART D Medications Please initial below if applicable ↓	**Listed are all prescribed medications(s) that I routinely take.** (Attach is a separate list, if necessary.)		
	Medication	Dosage	How often?
	I will self-administer the follwing medication(s)		
*	☐ Bronchial Inhaler		
*	☐ Diabetic Medication		
*	☐ Epi-pen		
*	☐ Other		

Over-The-Counter Medication(s):
Over-the-counter medications will be used to treat routine illness per treatment protocols. Acetaminophen is used in place of aspirin.

She can have ☐ Pain medications ☐ Cough syrup ☐ Antibiotic ointment ☐ Fever reducer
☐ Digestive relief ☐ Other: _____

I CANNOT have:

_____

_____

_____

_____

_____

Transportation Release: I authorize transportation by emergency vehicle to an appropriate health care facility and pre-hospital medical care, all hospital and physician services, whether medical, surgical and/or dental, necessary for my benefit, safety, and well-being. It is my expressed intention to hold Girl Scouts of Northern California harmless for any and all injuries, death, or damages arising from or in any way related to such transportation.

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. I hereby give permission to the licensed physician to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery should my medical emergency require this treatment. Should I become ill or exhibit COVID symptoms while participating at a trip or overnight event, I agree to either be tested for the COVID-19 virus using an over-the-counter test or leave the event as soon as possible.

The information disclosed on this form may be released to Volunteer/Staff responsible for this activity including, but not limited to troop/group leaders, drivers, medical personnel, etc. who have a need to know.

Authorization:

- To my best knowledge this health history is correct.
- I am able to engage in all planned trip activities except as noted by the examining physician.
- I acknowledge that an inherent risk of exposure to COVID-19 exists for any in-person activity, including meetings, activities, events, and trips.
- I am voluntarily assuming all risks related to exposure to COVID-19 and agree not to hold Girl Scouts of Northern California, or any of its directors, employees, agents or volunteers, liable for any illness or injury.

Participant Signature _____ **Date** _____

Print Name of Participant _____ **Phone** _____ **Email Address:** _____

Record of Health Examination: To be completed within 24 months of event 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 of exam: _____
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: _____

Name of Physician: _____

Signature of Physician: _____

Doctor's Office Address: _____

Phone: _____

Date Signed: _____