

## Adult Health History and Emergency Medical Authorization Form

This form is to be completed annually by adult volunteers and returned to the troop leader and/or troop first-aiders prior to attending the first troop meeting. Use additional paper if needed.

Adult's Name: \_\_\_\_\_ Volunteer Position(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_ E-mail: \_\_\_\_\_

### EMERGENCY CONTACTS

Emergency Contact 1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_ E-mail: \_\_\_\_\_

Emergency Contact 2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_ E-mail: \_\_\_\_\_

### HEALTH INFORMATION

Sex: ☐ Female ☐ Male Optional Information: Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### ALLERGIES AND HEALTH CONDITIONS (Check all that apply and provide requested information)

Allergies	Yes	No	Explain "yes" answers. Include the type of allergy (e.g. - "nut allergy" in the food category)
Animals	<input type="checkbox"/>	<input type="checkbox"/>	
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>	
Plants/Trees	<input type="checkbox"/>	<input type="checkbox"/>	
Food	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

	Condition	Dates		Condition	Dates		Condition	Dates
<input type="checkbox"/>	ADD/ADHD		<input type="checkbox"/>	Epilepsy		<input type="checkbox"/>	Nervous System Disorder	
<input type="checkbox"/>	Arthritis		<input type="checkbox"/>	Fainting		<input type="checkbox"/>	Pregnant	
<input type="checkbox"/>	Asthma		<input type="checkbox"/>	German Measles		<input type="checkbox"/>	Sickle Cell Anemia	
<input type="checkbox"/>	Athletes Foot		<input type="checkbox"/>	Hay Fever		<input type="checkbox"/>	Sinusitis	
<input type="checkbox"/>	Bleeding/Clotting Disorder		<input type="checkbox"/>	Headaches/Migraines		<input type="checkbox"/>	Skeletal Disease/Disorder	
<input type="checkbox"/>	Bronchitis		<input type="checkbox"/>	Hearing		<input type="checkbox"/>	Skin Conditions	
<input type="checkbox"/>	Cancer		<input type="checkbox"/>	Heart Defect/Disease		<input type="checkbox"/>	Sleep Disturbance/Walking	
<input type="checkbox"/>	Chicken Pox		<input type="checkbox"/>	Hypertension		<input type="checkbox"/>	Stomach Upsets	
<input type="checkbox"/>	Colds/Sore Throats		<input type="checkbox"/>	Kidney Disease		<input type="checkbox"/>	Urinary Tract Infections	
<input type="checkbox"/>	Constipation		<input type="checkbox"/>	Mononucleosis		<input type="checkbox"/>	Wear: <input type="checkbox"/> Contacts <input type="checkbox"/> Glasses	
<input type="checkbox"/>	Convulsions		<input type="checkbox"/>	Motion Sickness		<input type="checkbox"/>	Other: _____	
<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	Mumps		<input type="checkbox"/>	Other: _____	
<input type="checkbox"/>	Ear Infections		<input type="checkbox"/>	Muscle Disease/Disorder		<input type="checkbox"/>	Other: _____	

Explain any specific needs or accommodations required: \_\_\_\_\_

Explain any psychiatric counseling or hospitalization: \_\_\_\_\_

Explain any operations or serious injuries: \_\_\_\_\_

Explain any disabilities or chronic or recurring illnesses: \_\_\_\_\_

Explain any activities that are discouraged by your physician: \_\_\_\_\_

Explain any dietary modifications: \_\_\_\_\_

Since your last health exam, have you had:	Yes	No	Explain "yes" answers. Provide details and dates.
A serious injury requiring medical attention?	<input type="checkbox"/>	<input type="checkbox"/>	
An illness lasting longer than one week?	<input type="checkbox"/>	<input type="checkbox"/>	
An in-patient hospital or emergency room treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
Restrictions from participating in any activities?	<input type="checkbox"/>	<input type="checkbox"/>	

## IMMUNIZATION HISTORY

Are all immunizations current? ☐ Yes ☐ No If not, state reason(s): \_\_\_\_\_

DTP or DT (Tetanus) Date: \_\_\_\_\_ Results: \_\_\_\_\_ Date of Last Health Exam: \_\_\_\_\_

## MEDICATION INFORMATION

Are any prescription medications being taken? ☐ Yes ☐ No Are any of the following used? ☐ Inhaler ☐ Epipen

Name of Medication	Reason for Medication	Dosage	Frequency

## MEDICAL CARE AND INSURANCE INFORMATION

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_ Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Date of Last Health Exam: \_\_\_\_\_

Company Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## AUTHORIZATION FOR MEDICAL CARE

This health history is correct so far as I know. I can engage in all activities except as noted. I hereby give permission to the First-Aider or Adult-In-Charge to provide routine health care if I am unable to do so myself. I consent to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my participation in any activity sponsored by Girl Scouts of the USA, Girl Scouts Nation's Capital, or individual units. Should a medical emergency arise during my participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact my designated alternate at the phone numbers I have given. If it is believed my life or health may be adversely affected by the delay that an attempt to contact my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_