



Girl Scouts of Central Maryland
 4806 Seton Drive
 Baltimore, MD 21215-3247
 T (410) 358-9711, (800) 492-2521
 F (410) 358-9918
 www.gscm.org

GIRL & ADULT HEALTH HISTORY RECORD

This health history is to be completed on both sides & signed by parents/guardians of girls or by adult members themselves.

Name	Date of Birth	Age
Address	Troop or Group No.	
Parent/Guardian	(Area Code)Phone	
Home Address		
Business Address	(Area code) Phone	
In Emergency Notify	Relationship	
Address	(Area Code) Phone	
Name of Family Physician:	(Area Code) Phone	
Family Medical/Hospital Insurance carrier:	Policy or Group No.	

Part I: Illnesses and injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness

- | | | | | |
|----------------------|-----------------------------|--------------|----------|-----------------|
| Ear Infection | Bleeding/Clotting Disorders | Hypertension | Asthma | |
| Heart Defect/Disease | Musculoskeletal Disorders | Seizures | Diabetes | Other (Specify) |

Date of last health examination:

Were any complicating medical problems noted in last health examination? _____
 Is participant currently under the care of a physician or psychologist? _____
 Since last health exam, has participant had:
 a serious injury requiring medical attention? _____ an illness lasting more than five days? _____ treatment in a hospital or emergency room? _____
 any prescribed or over-the-counter medication _____ a surgical operation or fracture? _____
 any exposure to a contagious disease? _____ any restrictions concerning physical activities? _____ 02-779
Please explain any "yes" answers to the above questions. Include dates: 02/05



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II: Allergies (Check those that apply and specify nature of allergic reaction.)

Animals _____
Pollen _____
Medicines/drugs _____
Plants _____

Hay Fever
Food
Insect stings
Other (specify)

Part III: Other health conditions (Check those that apply)

Bed wetting
Constipation
Menstrual cramps
Motion sickness
Nosebleeds
Sleep disturbances
Other (specify)

Emotional disturbances
Fainting
Hearing impairment
Sickle cell trait or disease
Special dietary regimen
Wears glasses or contact lenses

Part IV: Immunization History

Immunization:	Year Primary Series Completed	Year of Last Booster
D.P.T.		
Diphtheria		
Pertussis (whooping cough)		
Tetanus		
Td		
Measles		
Mumps		
Rubella		
(German measles)		
Oral polio		
Hbpv		
Tuberculin test (most recent)		Result
Other		

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

I know of no reasons(s) other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

Signature of parent/guardian _____ Date: _____

This health history is correct and I am able to engage in all prescribed activities except as noted.

Signature of adult _____ Date: _____

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