girl scouts of central maryland

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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.

Girl Name ______ Date of Birth ______ Age ______

Address ______ Troop or Group No. ______

Parent/Guardian Name ______ Phone ______

Home Address ______

Business Address ______ Phone ______

Name of Emergency Contact ______ Relationship to girl ______ Phone ______

Address ______

Name of Family Physician: ______ 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

Please explain any "yes" answers to the above questions. Include dates: ______

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

- ☐ Animals
- ☐ Hay Fever
- ☐ Pollen
- ☐ Food
- ☐ Medicines/drugs
- ☐ Insect stings
- ☐ Plants
- ☐ Other (specify) ______

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

☐ Bed wetting	☐ Menstrual cramps	☐ Nosebleeds	☐ Other (specify)
☐ Emotional disturbances	☐ Hearing impairment	☐ Special dietary regimen	______
☐ Constipation	☐ Motion sickness	☐ Sleep disturbances	______
☐ Fainting	☐ Sickle cell trait or disease	☐ Wears glasses/contact lenses	______

Part IV: Immunization History

Immunization:	Year Primary Series Completed	Year of Last Booster
D.P.T. *Diphtheria, Pertussis, 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 parent/guardian

______ Date