girl scouts of louisiana pines to the gulf

GIRL & ADULT HEALTH HISTORY RECORD

This health history is to be completed and signed by parent/guardian of girls or by adult members themselves.

This is a confidential document. Information should only be share on an as needed basis.

Name | Date of Birth | Age

Address | City/Zip | Troop/Group Number

Parent/Guardian | (Area Code) Phone | Cell Phone

Home Address

Business Address | (Area Code) Phone | Cell Phone

In Emergency Notify: Name | Relationship

Address | (Area Code) Phone | Cell Phone

Name of family physician: | (Area Code) Phone

Family medical/hospital | Policy or Group Number insurance carrier:

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 ☐ Hypoglycemia

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? _____

Is participant currently taking any prescription medication? _____

Since last health exam, has participant had:

- a serious injury requiring medical attention? _____
- an illness lasting more than five days? _____
- any prescribed or over-the-counter medication? _____
- a surgical operation or fracture? _____
- treatment in a hospital or emergency room? _____
- any restrictions concerning physical activities? _____
- any exposure to a contagious disease? _____

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

_____

_____

Part 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 and specify nature of allergic reactions.)

_____Bed wetting
_____Constipation
_____Menstrual cramps
_____Motion sickness
_____Nosebleeds
_____Sleep disturbances
_____Attention deficit disorder
_____Emotional disturbances
_____Fainting
_____Hearing impairment
_____Sickle cell trait or disease
_____Special dietary regimen
_____Wear glasses or contact lenses
_____Other (specify) _____

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. _____

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P.	_____	_____
Diphtheria		_____
Tetanus		_____
Pertussis (Whopping Cough)		_____
TD	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella (German Measles)	_____	_____
Oral Polio	_____	_____
Hib	_____	_____
Hepatitis B	_____	_____
Tuberculin Test (most recent)	_____ Result	_____
Other_____		

This health history is completed and accurate. I know of no reason(s) why my daughter should not participate in prescribed activities except as noted.

Signature of Parent/Guardian _____ Date_____

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

Signature of Adult _____ Date_____