



**MINOR & ADULT HEALTH HISTORY RECORD**  
 This health history is to be completed and signed by  
**parents/guardians of minor members or by adult members themselves**

|                                   |                             |             |
|-----------------------------------|-----------------------------|-------------|
| <b>Full Name:</b>                 | <b>Date of Birth:</b>       | <b>Age:</b> |
| <b>Home Address:</b>              | <b>Troop Number:</b>        |             |
| <b>Parent/Guardian Full Name:</b> | <b>Home Phone:</b>          |             |
| <b>Home Address:</b>              | <b>Cell Phone or Pager:</b> |             |
| <b>Business Address:</b>          | <b>Business Phone:</b>      |             |

In Emergency Notify: \_\_\_\_\_ at \_\_\_\_\_  
 (Name & Relationship) (Phone number with area code)

If they are not available, notify: \_\_\_\_\_ at \_\_\_\_\_  
 (Name & Relationship) (Phone number with area code)

Family Physician: \_\_\_\_\_ at \_\_\_\_\_  
 (Name) (Phone number with area code)

Insurance Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_ Policy/Group Number: \_\_\_\_\_

**Section 1: Illnesses and injuries (check those that apply and explain below)**

**Chronic or Recurring illness**

Ear Infection       Bleeding/Clotting Disorders       Hypertension       Asthma  
 Heart Defect/Disease       Seizures       Diabetes  
 Other (specify & explain) \_\_\_\_\_

Date of last Health Exam: \_\_\_\_\_ Were any complicating medical problems or any conditions requiring monitoring or follow-up noted in the last health exam? Explain on a separate piece of paper if needed.

Is participant currently under the care of a physician or psychologist? \_\_\_\_\_

**Since the last health exam, has participant had:**

An injury or medical condition requiring medical attention? \_\_\_\_\_ An illness lasting more than five days? \_\_\_\_\_  
 Any exposure to a contagious disease? \_\_\_\_\_ A surgical operation or fracture? \_\_\_\_\_  
 Treatment in a hospital, outpatient clinic, or emergency room? \_\_\_\_\_ Any restrictions of physical activities? \_\_\_\_\_  
 Any prescribed or over-the-counter medications? \_\_\_\_\_ Is participant currently taking any medication? \_\_\_\_\_

**Please explain any check marks or "yes" answers to the above questions. Attach an extra sheet if necessary. Be as detailed as possible. Include dates, dosage of medications, etc:**

**Section II: Allergies (Check those that apply and specify nature of allergic reaction in open space below)**

Animals       Hay Fever       Pollen       Food       Plants       Insect stings  
 Medicine/drugs      \_\_\_\_\_ Is participant currently taking any allergy medication?  
 Other (Specify) \_\_\_\_\_

**\*\*\*\*Explain any checks. Also, please specify type of reaction and symptoms noted, and any particular treatment in case of exposure to allergy or allergic reaction:**

**Turn this page over for other important information**

**Section III: Other Health Conditions (Check those that apply explain in open space below)**

Bed wetting                       Emotional disturbances                       Constipation                       Fainting  
 Menstrual cramps                       Motion sickness                       Hearing impairment                       Nosebleeds  
 Sleep disturbances                       Dietary restrictions                       Glasses/contact lenses                       Anemia  
 Other (Specify)

**Section IV: Immunization History – Attach a copy of current Immunization History to this form.**

You may attach a copy of the school immunization form available from your physician or your local health center.

**Section V: Over the counter medications**

You may use this space to indicate any over the counter medications that your daughter is allowed to take if necessary. Please indicate the usual dosage that you would administer. Only the adult certified in First Aid or other adult in charge of activity will be allowed to administer the medication based on your instructions. Any medications, along with written instructions for dosage, that your daughter must take while participating in a Girl Scout Activity must be given to the adult certified in First Aid or other adult in charge of activity prior to departure. The only exceptions to this shall be PRN inhalers or epi-kits that your daughter has been trained to self-administer (adult certified in First Aid and other adults in charge of activity must be made aware if your daughter is carrying such item).

**FOR MINOR PARTICIPANTS**

**This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted. If this information changes during the Girl Scout year I will notify the leader in writing. I understand that this information will remain confidential to the troop/group/program leaders, designated person trained in first aid, or emergency personnel as needed. I hereby give permission to the adult in charge to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the adult in charge to arrange necessary related transportation for my child.**

\_\_\_\_\_  
(Signature of parent or legal guardian)

\_\_\_\_\_  
(Date this form was signed)

**FOR ADULT PARTICIPANTS**

**This health history is complete and accurate. I am able to participate in prescribed activities except as noted. If this information changes during the Girl Scout year I will notify the leader in writing. I understand that this information will remain confidential to the troop/group/program leaders, designated person trained in first aid, or emergency personnel as needed.**

\_\_\_\_\_  
(Signature of adult participant)

\_\_\_\_\_  
(Date this form was signed)