girl scouts
heart of michigan

Girl/Adult Health History Form

To be completed annually by parents/guardian or adult participant. This form is confidential and to be kept with the individual's records.
This information is requested on an annual basis so we can best take care of you/your daughter and ensure safety.

Participant Information:

Name: ______________________________ Date of Birth: ______________

Phone: (____) ______________ Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Parent/Guardian Information:
Participant is under the custodial care of: (please check one)
☐ Both Parents ☐ Mother/Guardian only ☐ Father/Guardian only ☐ Other (specify) ______________

Parent/Guardian Name: ______________________________
Address (if different than girl): ______________________________
Phone (day): ______________ Phone (evening): ______________ Cell: ______________
Email: ______________________________

Parent/Guardian Name: ______________________________
Address (if different than girl): ______________________________
Phone (day): ______________ Phone (evening): ______________ Cell: ______________
Email: ______________________________

Emergency Contact Information:
In the event that I cannot be reached in an emergency, the following are authorized to act in my behalf:

Name: ______________________________ Phone: ______________

Address: ______________________________ Email: ______________

City: ______________ State: ______________ Zip: ______________

Relationship to Participant: ______________________________

Name: ______________________________ Phone: ______________

Address: ______________________________ Email: ______________

City: ______________ State: ______________ Zip: ______________

Relationship to Participant: ______________________________

Health Care Information:

Last Exam Date: ______________________________

Physician's Name: ______________________________ Phone: ______________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Do you carry family medical/hospital insurance? ☐ Yes ☐ No

If yes, please complete the following information:

Insurance Company: ______________________________ Policy/Group #: ______________

Through (employer)______________________________ Insured Name (parent): ______________________________

List of past medical treatments (if any): ______________________________

____

____

List any current, physical, medical or psychological conditions requiring medical treatment or special restrictions or considerations: ______________________________

____

Allergies: (Check those that apply, specify what reaction to look for and what treatments recommended).

☐ Penicillin/Other Medications ______________________________

☐ Food Allergies ______________________________

☐ Bee/wasp/insect bites ______________________________

☐ Plants (poison ivy, etc.) ______________________________

☐ Animals (dogs, horses, etc.) ______________________________

Immunization Status (Indicate date

☐ Tetanus ______________________ ☐ Hepatitis B ______________________ ☐ TB ______________________

Are all immunizations up to date? ☐ Yes ☐ No

Please list any medications taken on a regular basis (over the counter or/and prescription):

Additional health conditions or limitations we should be aware of: ______________________________

____

Please list any dietary restrictions: ______________________________

____

Please list any activities the participant should be exempted from due to health reasons: ______________________________

____

Consent and Permission to Treat

In the event that reasonable attempts to contact me, or my designated emergency contacts, in an emergency have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary. This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why this individual should not participate in prescribed activities.

Signature of parent/guardian: ______________________________

Date: ______________________

Print Name: ______________________________