



Girl Scouts Heart of Michigan Girl/Adult Health History Form

To be completed annually by parent/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 _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Parent/Guardian Information:

She is under the custodial care of:

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: _____ Relationship to Participant: _____

Address _____ City _____ State _____ Zip _____

Phone (day) _____ Phone (evening) _____ Cell # (____) _____

Name: _____ Relationship to Participant: _____

Address _____ City _____ State _____ Zip _____

Phone (day) _____ Phone (evening) _____ Cell # (____) _____

Health Care Information:

Physician's Name: _____ Phone # _____ Last Exam Date: _____

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) _____

Allergies: Check those that apply, specify what reaction to look for and what treatment is recommended.

Penicillin /Other Medications _____

Food Allergies _____

Bee/wasp/insect bites _____

Plants (poison ivy, etc) _____

Animals (dogs, horses, etc) _____

Other _____

Immunization Status (Indicate Date): Tetanus _____ Hepatitis B _____ TB _____

Please list any medications taken on a regular basis: _____

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

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 information indicated on this form, why this individual should not participate in prescribed activities except where noted.

Signature of parent/guardian: _____ Date: _____