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: _____

(Over)

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: _____