Adult Health History

To be completed and signed by adult

Section 1 - Health History
Section 2 – Extended Travel (3+ Days) Health Form
Section 3 – Extended Travel (3+ Days) Physician Exam

Adult Full Name:	**Date of Birth:**	**Age:**
Address:		
Phone:	**Email:**	
Physician's Name:	**Phone:**	
Emergency Contact:	**Phone:**	**Relationship:**

Medical History - Check all that apply

	Arthritis		Fainting/dizzy spells		Menstrual cramps
	Asthma		Headaches/Migraines		Musculoskeletal Disorders
	Bedwetting		Hearing Impairment		Mental/Psychological Disorders
	Bleeding disorder		Speech Impairment		Nosebleeds
	Convulsions/Epilepsy/ Seizures		Heart Defects/Disease		Sinusitis (Sinus Infections)
	Diabetes		Hernia		Sleep Disturbances
	Diseases of the Ear or Ear Infections		Hypertension/High Blood Pressure		Sleep Impairment
	Eating Disorders (Anorexia, Bulimia, etc.)		Intestinal Disorders/Constipation		Other:
	Eyesight Impairment		Kidney/bladder illness		
	Currently Under Physician/Psychologist care		Had Surgery/Hospitalized in the last 5 years		

Date of last health examination: ____________________
Were any complicating medical problems noted in the last health exam: __Yes __No

Please explain in detail any items checked above:

Are all immunizations current? __Yes/__No If not, state reason(s):

DTP or DT (Tetanus) Date:

Allergies - List ALL allergies (including medications, food, bees, etc.), the type of reaction/severity, treatment and date of last reaction.

Allergies	Reaction/Severity	Treatment	Date of Last Reaction

Comments:

Do you suffer from anaphylaxis?* Yes ☐ No ☐

*A severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.
Do you carry an Epipen? Yes ☐ No ☐ Do you carry an inhaler? Yes ☐ No ☐

Prescribed Medications - I take the following medications.			
Medication	**Purpose**	**Dosage**	**Special Instructions**
Other:			
Special considerations or notes:			

Over the Counter Medications & Dietary Restrictions			
	I do not take over the counter medication (please include over the counter medication allergies above).		
	I can take the following over the counter medications daily or in case of accident/injury/sickness (for example pain reliever, digestive relief, etc.). Please include dosage as necessary.		
Special consideration or notes:			
I have the following dietary restrictions:			

Health Insurance Information (In case of accident or illness, personal insurance is primary, Girl Scout insurance is secondary)			
Policy Holder Name		Insurance Company	
Policy Number		Insurance Company Address	
Group Number		Insurance Company Phone Number	

Initial and Sign

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact, by contact with contaminated surfaces and objects, and possibly in the air. People reportedly can be infected and spread the disease even if they do not show any symptoms. Girl Scouts of Western Washington ("GSWW") is committed to taking precautions to mitigate that risk as well as to following applicable federal, WA State, local and GSUSA COVID-19 directives and guidelines. Our council is also committed to having in-person activities as allowed and in accordance with those mandates. GSWW's operations and programs occurring while COVID-19 is circulating in our community may expose our members, volunteers, and employees to the risk of infection. GSWW cannot prevent you from becoming exposed to, contracting or spreading COVID-19 while attending (which includes being present in any capacity) any GSWW in-person programming. Therefore, any interaction with others in connection with in-person programming may expose you and your family to and increase your risk of contracting or spreading COVID-19. GSWW has put in place preventative measures to reduce the spread of COVID-19 at its in-person programming; however, GSWW cannot guarantee that you will not become infected with COVID-19.

By participating in these in-person activities, participants will be viewed as: 1.) Understanding that COVID-19 is a highly contagious virus, easily spread including through in-person contact; 2.) Acknowledging that GSWW cannot guarantee that infection will not occur; 3.) Choosing to accept the risk of contracting COVID-19 for the participant and their family in order to attend the in-person activity; and 4.) Agreeing to release GSWW from responsibility in the event of COVID-19 infection. Participants who do not agree to these statements should not join in-person GSWW activities.

Initial:

This health history is correct and I am able to participate in all prescribed activities except as noted.

Signature: Date:

Section 2 – Extended Travel (3+ Days) Health Form – to be completed by Adult

Secondary Emergency Contact			
Name		**Phone**	
Relationship		**Secondary Phone**	
Email			

Additional Medical History Check all that apply			
	Chicken Pox		Mumps
	German Measles		Rheumatic Fever
	Kidney Disease		Tuberculosis
	Measles		Other:
Please explain in detail any items checked above:			

Medical Conditions and/or Concerns

Please include any precautions or restrictions on activities, as well as concerns relating to emotional and mental well-being (including self-harm, depression, effects of medication on their behavior, eating disorders, etc.). We want to provide the most supportive environment possible, and a large part of that is knows what's going on with trip participants. The more information you provide, the better we can to work with you to establish a plan.

Name of Condition	Effects
Additional Information or Comments:	
Have you had any adverse reactions to general anesthetics? Yes No	

Adult Name___________________________

Rev. 03/21

Adult Name______________________________

Section 3–Extended Travel (3+ Days) Health Examination Form – to be completed by Physician

Trip Information - Must be completed by Adult	
Trip/Activity:	
Region/Location:	Date Range of Trip/Activity:
Distance from Emergency Medical Services:	Level of First Aid Required:
Trip/Activity Description: Include a brief description of your trip. This will help the medical professional evaluate your physical readiness for the trip. Please note if different activities will be done (ex. rock climbing, cultural sites, etc.)	

Record of Immunization - Complete in detail or attach documentation

Immunization	Date Series Completed	Year of Last Booster	Immunization	Date Series Completed	Year of Last Booster
Hepatitis B			Hepatitis A		
Diphtheria, Tetanus, Pertussis (DTap/Tdap)			Inactivated Poliovirus (IPV)		
Measles, Mumps, Rubella MMR)			Influenza		
Rotavirus (RV)			Varicella		
Haemophilus influenzae type b (Hib)			Meningococcal (MCV)		
Pneumococcal (PCV)			Human Papillomavirus (HPV)		
IPV/OPV			Typhoid		
Paratyphoid			Cholera		
Yellow Fever			Typhus		
Rocky Mountain			Spotted Fever		
Rota			Other		
Tuberculin Test Year last given:			Results:		

Medical Examination Form - Must be completed by a licensed physician, nurse practitioner, physician assistant or registered nurse within the preceding 12-24 months, unless a health issue is present.

Height:	Weight:	Blood pressure:	Pulse Rate:
Hearing: R: L:	Eyes: With Glasses R 20/ L20/	Eyes: Without Glasses R 20/ L20/	

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

	Nose		Lungs		Urinalysis		Musculoskeletal
	Throat		Abdomen		HGB		General Physical State
	Teeth		Hernia		Skin		General Emotional State
	Heart		Genitalia		Appearance/Nutrition		Other

Licensed Physician Name:____________________________________ State License Number:__________________

Phone Number:__________________

Address:______________________________________ City:__________________ St:_____Zip:_________________

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted. Yes No

Signature of Licensed Physician:____________________________________Date: ___________________________