

Girl Scouts of Western Washington
Girl or Adult Health History Record

This health history is to be completed & signed by parent/ guardian of girls or by adult members for themselves.

Name (girl adult): _____ Date of Birth: _____ Age: _____

Address: _____ Troop No. _____

Parent/Guardian: _____ Day phone: () _____

Address: _____ Phone #: () _____ Phone # _____

Doctor's name: _____ Dr. Phone #: () _____

Emergency Contact: _____ Phone #: () _____

Part 1: Illnesses & injuries (check those that apply & give approximate dates)

Chronic or Recurring Illness:

- Ear infection Bleeding/clotting disorders Hypertension Asthma Heart defect/disease
 Musculoskeletal disorders Seizures Diabetes Other _____

Date of last health examination: _____ Is participant under a doctor/psychologist's care now? Yes No

Were any complicating medical problems noted in the last health exam? Yes No

Since last health exam, has participant had:

- | | | | |
|---|--|---|--|
| A serious injury requiring medical attention? | <input type="checkbox"/> Yes <input type="checkbox"/> No | An illness lasting more than five days? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any prescribed or over the counter medications? | <input type="checkbox"/> Yes <input type="checkbox"/> No | A surgical procedure or fracture? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Treatment in a hospital or emergency room? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any exposure to a contagious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any restrictions concerning physical activity? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN, INCLUDING DATES:

Part 2: Allergies (Check those that apply & specify nature of allergic reaction)

- | | |
|---|---|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Hay fever _____ |
| <input type="checkbox"/> Pollen _____ | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Meds/drugs _____ | <input type="checkbox"/> Insect stings _____ |
| <input type="checkbox"/> Plants _____ | <input type="checkbox"/> Other(specify) _____ |

Part 3: Other health conditions (Check those that apply)

- | | |
|---|---|
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Emotional disturbances |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Sickle cell trait or disease |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Special diet regime |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Wear glasses or contact lens |
| <input type="checkbox"/> Other (Please specify) _____ | |

Part 4: Immunization history:

Immunization:	Year primary series completed	Year of the last booster
D.P.T.	_____	_____
Diphtheria	_____	_____
Pertussis (whooping cough)	_____	_____
Tetanus	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
(German Measles)	_____	_____
Oral Polio	_____	_____
HbPV	_____	_____
Tuberculin test (most recent)	_____	_____
Other: _____		

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to ANY of these health conditions. Also, please indicate any activities to be encouraged or restricted.

For Parents: 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.

Signature of parent/guardian: _____ **Date:** _____

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

Signature of adult: _____ **Date:** _____