Girl Scouts of Central California South
Health History and Medical Examination Form for Adults

Health History: The more complete information you provide, the better we are able to work with you to ensure you receive the care you need.

Medical Examination: A medical examination is completed for trips lasting more than three nights. The examination is completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months unless a health issue is present.

Please type or write clearly and legibly.

Name of Adult: (Last, First, Middle Initial)	**Date of Birth:** (XX/XX/XXXX)		**Sex:** **M F**
Address:	**City:**	**St:**	**Zip:**
Spouse (if applicable):	**Phone:**	**Alternate Phone:**	

Emergency Contact Information:

Emergency Contact:	**Relationship:**
Phone:	**Alternate Phone:**

Health Insurance Information (Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply and explain in detail checked answers:

___	Diabetes	___	Eyesight Impairment
___	Heart Defects/Disease	___	Hearing Impairment
___	Asthma or Hay Fever	___	Speech Impairment
___	Diseases of the Ears or Ear Infections	___	Intestinal Disorders/Constipation
___	Musculoskeletal Disorders	___	Chicken Pox
___	Convulsions/Epilepsy/Seizures	___	Measles
___	Sinusitis (Sinus Infections)	___	German Measles
___	Physical Restrictions	___	Mumps
___	Kidney/bladder illness	___	Rheumatic Fever
___	Mental/psychological disorder	___	Tuberculosis
___	Hypertension/Abnormal Blood Pressure	___	Kidney Disease
___	Arthritis	___	Eating Disorders (Anorexia, Bulimia, etc.)
___	Nosebleeds	___	Headaches/Migraines
___	Hernia	___	Had surgery or hospitalized in the last 5 years
___	Menstrual cramps	___	Currently under doctor's care
___	Bleeding disorder	___	Other: _____

Please explain in detail all checked answers marked above:

Adult Name: _____

Allergies: Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Do you suffer from Anaphylaxis? Yes No
*Anaphylaxis is 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

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Medications: List any medications currently taken (or has taken in the recent past) including dosage schedule and specific instructions for use.

Medication	Purpose	Dosage Schedule	Specific Instructions
1.			
2.			
3.			
4.			
5.			

Over-the-Counter Medications: In case of accident or injury. Please check all that apply:

- ☐ Tylenol/Acetaminophen
- ☐ Aspirin (fever reducer)
- ☐ Ibuprofen (pain/swelling)
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/expectorant
- ☐ Sudafed/decongestant
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Imodium (anti-diarrhea)
- ☐ Dramamine (motion sickness prevention)
- ☐ Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
- ☐ Other: _____
- ☐ Other: _____

Special considerations or notes regarding over-the-counter medications:

Do you have a Special Medical or Dietary Regiment to be followed? Yes No
If so, please explain: _____

Have you ever had any adverse reactions to general anesthetics? Yes No
If so, please explain: _____

Additional information that is important for other advisors on this trip to know about: _____

_____

Adult Name: _____ **Date:** _____

(This section is to be completed by a physician after the review of health history. Adult must complete all the information in the Health History to the best of their knowledge and sign before meeting with licensed professional.)

Medical Examination

Height: _____ Weight: _____ Pulse Rate: _____ B. P.: ____/____

Sugar: _____ Albumin: _____ Blood Hemoglobin: _____

Hearing: R ___ L ___ Eyes: With Glasses R 20/____ L 20/____ Without Glasses R 20/____ L 20/____

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

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

*Girls should have this test if she had not had it since entering puberty.

Does this applicant have any conditions which might limit activity for this event/travel/assignment; such as chronic disease, weight or limit participation in swimming or other strenuous activity? Yes No

If yes, please explain: _____

_____

Record of Immunization

	Date Series was Completed	Year of Last Booster		Date Series was Completed	Year of Last Booster
Hep B	_____	_____	Typhoid	_____	_____
DTap/Tdap	_____	_____	Paratyphoid	_____	_____
DT/Td	_____	_____	Cholera	_____	_____
Hib	_____	_____	Yellow Fever	_____	_____
IPV/OPV	_____	_____	Typhus	_____	_____
PCV7	_____	_____	Rocky Mountain Spotted Fever	_____	_____
MMR	_____	_____			
Varicella	_____	_____	Tuberculin Test: Year last given	_____	Result _____
Other:			Not required immunizations, but recommended		
_____	_____	_____	HPV	_____	_____
_____	_____	_____	Rota	_____	_____
_____	_____	_____	MCV4/MPSV4	_____	_____
_____	_____	_____	Hep A	_____	_____
_____	_____	_____	TIV/LAIV	_____	_____

Physician Information

Licensed Physician Name: (Last, First, Middle Initial)	**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.

Signature of Licensed Physician: _____ **State License Number:** _____ **Date:** _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Adult Health History and Medical Examination Form** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years in the case of treatment. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Adult Health History and Medical Examination Form is complete and accurate.

Signature of Adult Participant: _____ **Date:** _____