



Adult Health History Form

Please type or write clearly and legibly.

Name of Adult: (Last, First, Middle Initial)	Date of Birth: (XX/XX/XXXX)		
Address:	City:	St:	Zip:

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:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sleep Disturbances
<input type="checkbox"/> Heart Defects/Disease	<input type="checkbox"/> Fainting
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Constipation
<input type="checkbox"/> Musculoskeletal Disorders	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Convulsions/Epilepsy/Seizures	<input type="checkbox"/> Measles
<input type="checkbox"/> Sinusitis (Sinus Infections)	<input type="checkbox"/> German Measles
<input type="checkbox"/> Physical Restrictions	<input type="checkbox"/> Mumps
<input type="checkbox"/> Kidney/bladder illness	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Mental/psychological disorder	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eating Disorders (Anorexia, Bulimia, etc.)
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Headaches/Migraines
<input type="checkbox"/> Has begun menstruation	<input type="checkbox"/> Had surgery or hospitalized in the last 5 years
<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Currently under doctor's care
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Emotional – Separation Anxiety
<input type="checkbox"/> Other:	

Please explain in detail all checked answers marked above:

Adult Health History Form (Continued)

Name: _____

Date: _____

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.	

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

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

Over-the-Counter Medications: Please check all that you are giving us permission to administer to you:

- | | |
|---|---|
| <input type="checkbox"/> Tylenol/Acetaminophen
<input type="checkbox"/> Aspirin (fever reducer)
<input type="checkbox"/> Ibuprofen (pain/swelling)
<input type="checkbox"/> Benadryl/Antihistamine
<input type="checkbox"/> Robitussin/expectorant
<input type="checkbox"/> Sudafed/decongestant
<input type="checkbox"/> Pepto Bismol
<input type="checkbox"/> Tums/antacid | <input type="checkbox"/> Imodium (anti-diarrhea)
<input type="checkbox"/> Dramamine (motion sickness prevention)
<input type="checkbox"/> Skin Ointments (in case of rash, Anti-bacterial, athlete's foot, etc.)
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____ |
|---|---|

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

Does 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: _____

Any other information not covered in this form that is important that advisors for this trip know: _____

This *Health History Form* is complete and accurate. In case of a medical emergency, I hereby give authorization to USAGSO to seek treatment for me by a licensed physician.

Signature of Adult Participant : _____

Date: _____