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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:

☐	Diabetes	☐	Sleep Disturbances
☐	Heart Defects/Disease	☐	Fainting
☐	Asthma	☐	Bed wetting
☐	Ear Infections	☐	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	☐	Kidney Disease
☐	Arthritis	☐	Eating Disorders (Anorexia, Bulimia, etc.)
☐	Nosebleeds	☐	Headaches/Migraines
☐	Has begun menstruation	☐	Had surgery or hospitalized in the last 5 years
☐	Menstrual cramps	☐	Currently under doctor's care
☐	Bleeding disorder	☐	Emotional – Separation Anxiety
☐	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 your 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:

☐ 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, Anti-bacterial, athlete's foot, etc.)
☐ Other:
☐ 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:**