girl scouts of colorado

Adult Health History for Extended Trips

The **Medical Examination** on page 3 is required for all international extended trips and encouraged for all extended trips (3 nights or more). It needs to be completed within the preceding 24 months of the trip.

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: _____

Health Information Privacy Statement: This form will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. 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 this form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Permission for Emergency Medical Treatment: In case of emergency, I give my permission to persons representing Girl Scouts of Colorado to see that I receive appropriate emergency medical or surgical treatment, and/or hospitalization if necessary. It is understood that every effort will be made to reach the person named above.

This form is complete and accurate.

Signature of Adult Participant: _____ Date: _____

Medical Examination

To be completed by a physician after the review of health history.

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	_____

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
Hep B	_____	_____
DTap/Tdap	_____	_____
DT/Td	_____	_____
Hib	_____	_____
IPV/OPV	_____	_____
PCV7	_____	_____
MMR	_____	_____
Varicella	_____	_____
Other:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

	Date Series was Completed	Year of Last Booster
Typhoid	_____	_____
Paratyphoid	_____	_____
Cholera	_____	_____
Yellow Fever	_____	_____
Typhus	_____	_____
Rocky Mountain Spotted Fever	_____	_____

Tuberculin Test: Year last given_____ Result _____

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: _____