



FOR CAMP USE ONLY	
Session Name	_____
Session Code	_____
Session Dates	_____

## ADULT HEALTH HISTORY

Name \_\_\_\_\_  Male  Female Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**IN CASE OF EMERGENCY, NOTIFY:**

Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Last Health Exam \_\_\_\_\_ Physician's Name \_\_\_\_\_ Physician's Phone \_\_\_\_\_  
 Were there any complicating medical problems noted? \_\_\_\_\_

IF SWIMMING, HORSEBACK RIDING OR STRENUOUS ACTIVITIES ARE TO BE A PART OF THE PROGRAM, A STATEMENT FROM A LICENSED PHYSICIAN AS TO YOUR GENERAL CONDITION AND YOUR ABILITY TO PARTICIPATE IN ALL PROGRAM ACTIVITIES MUST ACCOMPANY THIS FORM.

**HEALTH HISTORY:**

Please check and give dates if you have any of the following conditions:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Ear Infections _____             | <input type="checkbox"/> Hypertension _____              | <input type="checkbox"/> German Measles _____ |
| <input type="checkbox"/> Convulsions _____                | <input type="checkbox"/> Musculoskeletal Disorder _____  | <input type="checkbox"/> Mumps _____          |
| <input type="checkbox"/> Diabetes _____                   | <input type="checkbox"/> Plant/Pollen Allergies _____    | <input type="checkbox"/> Asthma _____         |
| <input type="checkbox"/> Heart Defect/Disease _____       | <input type="checkbox"/> Insect Sting Allergy _____      | <input type="checkbox"/> Chicken Pox _____    |
| <input type="checkbox"/> Bleeding/Clotting Disorder _____ | <input type="checkbox"/> Drug Allergies (specify) _____  | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Hepatitis B Carrier _____        | <input type="checkbox"/> Other Allergies (specify) _____ |   |

Date of last Tetanus booster \_\_\_\_\_

Details of above conditions \_\_\_\_\_

**Other health conditions: (Check all that apply)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Frequent constipation | <input type="checkbox"/> Special dietary regimen | <input type="checkbox"/> Hearing impairment   |
| <input type="checkbox"/> Menstrual cramps      | <input type="checkbox"/> Emotional disturbances  | <input type="checkbox"/> Wear glasses         |
| <input type="checkbox"/> Sleep disturbances    | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Wears contact lenses |

Please explain items checked: \_\_\_\_\_

Are there other health concerns the Health Supervisor/Troop Leader should be aware of?  Yes  No If yes, explain \_\_\_\_\_

Are you currently under the care of a physician or psychologist?  Yes  No

Are you currently taking any medication?  No  Yes If yes, please list \_\_\_\_\_

**Since your last health examination, have you had: (Give dates and explain)**

- A serious injury requiring medical attention? \_\_\_\_\_
- Treatment in a hospital or emergency room? \_\_\_\_\_
- An illness lasting more than five (5) days? \_\_\_\_\_
- A surgical operation or fracture? \_\_\_\_\_
- Any restrictions concerning physical activities? \_\_\_\_\_

Do you consider yourself to be in good health and able to participate in normal program activities?  Yes  No

If no, please explain \_\_\_\_\_

Dietary considerations \_\_\_\_\_

If I am exposed to contagious disease in the three weeks prior to event/program, I will notify the director. To the best of my knowledge, this health history is correct.

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.

Signature \_\_\_\_\_

Date \_\_\_\_\_