



Girl & Adult Health History
 This health history is to be completed and signed by
 parents/guardians of girls or by adult members themselves

Name	Date of Birth	Age
Address	Troop No.	
Parent/Guardian	Phone No.	
Home Address		
Business Address	Phone No.	
In Emergency Notify (Name)	Relationship	
Address	Phone No.	
Name of Family Physician	Phone No.	
Family medical/hospital insurance carrier	Policy or Group No.	

Part I: Illnesses and Injuries (Check those that apply and give appropriate dates)

Chronic or recurring illness

- | | | | |
|-----------------------|-----------------------------|--------------|----------|
| Ear Infection | Bleeding/Clotting Disorders | Hypertension | Asthma |
| Heart Defect/Disease | Musculoskeletal Disorders | Seizures | Diabetes |
| Other (Specify) _____ | | | |

Date of last health examination _____

Were any complicating medical problems noted in last health examination? _____

Is participant currently under the care of a physician or psychologist? _____

Since last health exam, has participant had:

- | | |
|--|--|
| A serious injury requiring medical attention? _____ | An illness lasting more than five days? _____ |
| Any prescribed or over-the-counter medication? _____ | A surgical operation or fracture? _____ |
| Treatment in a hospital or emergency room? _____ | Any restrictions concerning physical activities? _____ |
| Any exposure to a contagious disease? _____ | |

Please explain any "Yes" answers to the above questions. Include dates:

Part II: Allergies (Check those that apply and specify nature of allergic reaction)

- | | |
|----------------------|-----------------------|
| Animals _____ | Hay Fever _____ |
| Pollen _____ | Food _____ |
| Medicine/drugs _____ | Insect bites _____ |
| Plants _____ | Other (specify) _____ |

Part III: Other Health Conditions (Check those that apply)

- | | |
|-----------------------|---------------------------------|
| Bed wetting | Emotional disturbances |
| Constipation | Fainting |
| Menstrual cramps | Hearing impairment |
| Motion Sickness | Sickle cell trait or disease |
| Nosebleeds | Special dietary regimen |
| Sleep disturbances | Wears glasses or contact lenses |
| Other (specify) _____ | |

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Booster
D.P.T. _____		
Diphtheria, Pertussis (Whooping cough)		
Tetanus _____		
TB _____		
Measles _____		
Mumps _____		
Rubella _____		
(German measles)		
Oral polio _____		
HBPV _____		
Tuberculin test (most recent) Result		
Other _____		

I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

Signature of parent/guardian _____ Date _____

This health history is correct and I am able to engage in all prescribed activities except as noted.

Signature of adult _____ Date _____