girl scouts of black diamond

Girl & Adult Health History

This health history is to be completed and signed by parents/guardians of girls or by adult members themselves.

Girl Scouts of Black Diamond Council follows HIPAA protocol when releasing information contained on this health history form.

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 on a separate sheet. Include dates.

Part II: Allergies

(Check those that apply and specify nature of allergic reaction)

☐ Animals _____ ☐ Hay Fever _____

☐ Pollen _____ ☐ Food _____

☐ Medicine _____ ☐ 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) _____

Part IV: Immunization History

Immunization	Year Primary Series Complete	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		

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.

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 _____