girl scouts of northern illinois

Adult Health History Form

Session Name _____ Dates _____

Personal Information - *Please complete the following:*

Name (Last, First, Initial)				Sex	Birth Date
Address	**City or Town**	**State**	**Zip**	**Phone**	
				( )	
In Emergency, Notify Name	**Address**		**Relationship**	**Phone**	
				( )	
In Emergency, Notify Name	**Address**		**Relationship**	**Phone**	
				( )	

Insurance Information - *Please complete the following:*

Carrier	ID Number	Group Number
Member Services Phone Number	**Address**	
( )		

Health History – *Please check if you have had any of the following:*

- ❑ Vision Impairment
- ❑ Hearing Impairment
- ❑ Speech Impairment
- ❑ Nervous System Disorder
- ❑ Sinusitis
- ❑ Lyme Disease
- ❑ Other _____
- ❑ Kidney Disease
- ❑ Heart Disease
- ❑ Rheumatic Fever
- ❑ Abnormal Blood Pressure
- ❑ Mental or Emotional Disorders
- ❑ Severe Menstrual Pain
- ❑ Arthritis
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Hernia
- ❑ Asthma or Hay Fever
- ❑ Other Serious Allergies
- ❑ Disease of Ears
- ❑ Intestinal Disorders
- ❑ Chicken Pox
- ❑ Measles
- ❑ Mumps
- ❑ German Measles

Date of Tetanus Shot (MM/YY): _____

Have you been hospitalized in the last five years? ☐ Yes ☐ No Are you taking any medication? ☐ Yes ☐ No

*If you have checked or answered "Yes" to any of the above, please give the following information (Use back of form for more room)***:**

Nature of Illness	Dates Afflicted (Start-End)	Period of Disability	Results/Outcome

Please list below any current medications being taken (Use back of form for more room):

Medication	Dosage *(How Much? How Many Times a Day?)*	Potential Harmful Interaction *(Food, Other Medications, Environment)*

I certify that, to the best of my knowledge, this health history is complete and accurate and that I am in good health and able to participate in this event/assignment.

Signature of Applicant _____ Date _____

INFORMATION PRIVACY STATEMENT

The Health Examination Record is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff volunteers in order to provide adequate participant safety and health care. This health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. 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 the health form information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I authorize emergency medical treatment be given if needed for illness or injury. This health history is complete and accurate.

Signature of Applicant _____ Date _____