

## Girl Scouts of Northern Illinois Health History Form for Adults For Domestic Travel

**Health History:** The more complete information you provide, the better we can work with you to ensure you receive the care you need.

*Please type or write clearly and legibly.*

|   |                                    |                         |             |
|---|------------------------------------|-------------------------|-------------|
| <b>Name of Adult:</b> (Last, First, Middle Initial) | <b>Date of Birth:</b> (XX/XX/XXXX) | <b>Sex:</b><br>M F NB   |             |
| <b>Address:</b>                                     | <b>City:</b>                       | <b>St:</b>              | <b>Zip:</b> |
| <b>Spouse (if applicable):</b>                      | <b>Phone:</b>                      | <b>Alternate Phone:</b> |             |

**Emergency Contact Information:**

|                           |                         |
|---------------------------|-------------------------|
| <b>Emergency Contact:</b> | <b>Relationship:</b>    |
| <b>Phone:</b>             | <b>Alternate Phone:</b> |

**Health Insurance Information** (Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)

|                                   |                                 |
|-----------------------------------|---------------------------------|
| <b>Policy Holder's Name:</b>      | <b>Policy Number:</b>           |
| <b>Insurance Company Name:</b>    | <b>Group Number:</b>            |
| <b>Insurance Company Address:</b> | <b>Insurance Company Phone:</b> |

**Check all that apply and explain in detail checked answers:**

|   |  |
|---|--|
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Eyesight Impairment                             |
| <input type="checkbox"/> Heart Defects/Disease                  | <input type="checkbox"/> Hearing Impairment                              |
| <input type="checkbox"/> Asthma or Hay Fever                    | <input type="checkbox"/> Speech Impairment                               |
| <input type="checkbox"/> Diseases of the Ears or Ear Infections | <input type="checkbox"/> Intestinal Disorders/Constipation               |
| <input type="checkbox"/> Musculoskeletal Disorders              | <input type="checkbox"/> Chicken Pox                                     |
| <input type="checkbox"/> Convulsions/Epilepsy/Seizures          | <input type="checkbox"/> Measles   |
| <input type="checkbox"/> Sinusitis (Sinus Infections)           | <input type="checkbox"/> German Measles                                  |
| <input type="checkbox"/> Physical Restrictions                  | <input type="checkbox"/> Mumps   |
| <input type="checkbox"/> Kidney/bladder illness                 | <input type="checkbox"/> Rheumatic Fever                                 |
| <input type="checkbox"/> Mental/psychological disorder          | <input type="checkbox"/> Tuberculosis                                    |
| <input type="checkbox"/> Hypertension/Abnormal Blood Pressure   | <input type="checkbox"/> Kidney Disease                                  |
| <input type="checkbox"/> Arthritis                              | <input type="checkbox"/> Eating Disorders (Anorexia, Bulimia, etc.)      |
| <input type="checkbox"/> Nosebleeds                             | <input type="checkbox"/> Headaches/Migraines                             |
| <input type="checkbox"/> Hernia                                 | <input type="checkbox"/> Had surgery or hospitalized in the last 5 years |
| <input type="checkbox"/> Menstrual cramps                       | <input type="checkbox"/> Currently under doctor's care                   |
| <input type="checkbox"/> Bleeding disorder                      | <input type="checkbox"/> Other: _____                                    |

Please explain in detail all checked answers marked above:

**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.         |         |                 |                       |

**Over-the-Counter Medications:** In case of accident or injury. Please check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Tylenol/Acetaminophen     | <input type="checkbox"/> Dramamine (motion sickness prevention)                                |
| <input type="checkbox"/> Aspirin (fever reducer)   | <input type="checkbox"/> Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.) |
| <input type="checkbox"/> Ibuprofen (pain/swelling) | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Benadryl/Antihistamine    | _____  |
| <input type="checkbox"/> Robitussin/expectorant    | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Sudafed/decongestant      | _____  |
| <input type="checkbox"/> Pepto Bismol              |  |
| <input type="checkbox"/> Tums/antacid              |  |
| <input type="checkbox"/> Imodium (anti-diarrhea)   |  |

**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:** \_\_\_\_\_

\_\_\_\_\_

**HEALTH INFORMATION PRIVACY STATEMENT**

The **Adult Health History** 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 for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years in the case of treatment. 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 and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

**This Adult Health History Form is complete and accurate.**

**Signature of Adult Participant:** \_\_\_\_\_

**Date:** \_\_\_\_\_