girl scouts of northern illinois

Girl Scouts of Northern Illinois
Health History Form for Adults

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.

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

Emergency Contact Information:

Emergency Contact:	Relationship:
Phone:	**Alternate Phone:**

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

Policy Holder's Name:	Policy Number:
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply and explain in detail checked answers:

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

Tylenol/Acetaminophen
Aspirin (fever reducer)
Ibuprofen (pain/swelling)
Benadryl/Antihistamine
Robitussin/expectorant
Sudafed/decongestant
Pepto Bismol
Tums/antacid
Imodium (anti-diarrhea)

Dramamine (motion sickness prevention)
Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
Other: ________________
____
Other: ________________
____

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:** _____________