



Adult Health History

Girl Scouts of Northern California with offices in:
 Alameda, Chico, Eureka, Red Bluff, Redding, San Jose,
 Santa Rosa, & Ukiah
 T (800) 447-4475
 F (510) 633-7925
 www.GirlScoutsNorCal.org

Part 1: Adult information

Adult Name: _____ Birth Date: _____ Female Male

Address/City/Zip: _____ Email: _____

Day Phone: _____ Evening Phone: _____ Cell Phone: _____

Health Information Privacy Statement

The Adult Health History 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. The health history record will be retained by the council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the council by the participant or their legal representative.
I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Adult Participant Signature: _____ Date: _____

Part 2: Insurance Information

Name of Dentist: _____ Phone #: _____

Name of Doctor: _____ Phone #: _____

Insurance Carrier Name: _____ Policy/Group Number: _____

Part 3: Allergies/illnesses/Injuries

Allergic Reactions: (Check those that Apply and specify nature of the allergic reaction)

- | | | | |
|----------------------------------|--|--|--|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Medicines/Drugs | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Food | <input type="checkbox"/> Insect stings | <input type="checkbox"/> Plants | <input type="checkbox"/> Other (specify) |

Check here for no known allergies

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

- | | | | |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Musculoskeletal Disorder | <input type="checkbox"/> Seizures |

Date of last health examination: _____
 If yes please explain: _____

Were any complicating medical problems noted? Yes No
 Other health conditions or injuries that might impact your participation? _____

Part 4: Medication

Are you taking any medications? Yes No

If YES, list medication, reason, and possible side effects

Medication	Possible Side Effects

Part 5: Consent to Treat

In the event of an emergency, every effort will be made to contact an emergency contact. I hereby give authorization to the Girl Scouts of Northern California to seek treatment for myself by a licensed physician pursuant to California Family Code Section 6910 and California Civil Code 25.8. I know of no reason(s), other than the information indicated on this form, why I should not participate in prescribed activities.

Adult Participant Signature: _____ Date: _____

Part 6: Emergency Contact(s)

Name	Relationship	Cell Phone	Day Phone	Evening Phone

Please review the information on this form annually. If there are no changes or just minor adjustments, please mark those, then sign and date this form where indicated

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____