



# Adult Health History and Medical Examination

The Adult Health History and Exam Combination Form pages are to be submitted as follows:

- **Health History:** These forms should be completed and submitted annually to the troop you are currently registered with. Additional copies may be required for other events or overnight activities. In addition, if you change anything or need to make an update, please give an updated copy to the troop. The adult participant (18 years or older) must complete and sign pages 1 & 2.
- **Medical Examination:** A Medical Examination and Health History are to be completed for trips lasting three nights or more and/or as required by council. Please review Volunteer Essentials & Safety Activity Checkpoints for details. The physical examination is to be completed by a licensed physician, nurse practitioner, physician's assistant, or registered nurse within the preceding 12 months unless a health issue is present. (Complete pages 1-3)

<b>Name of Adult:</b> (Last, First, Middle Initial)	<b>Date of Birth:</b>	<b>Sex Assigned at Birth</b> F    M	<b>Gender</b> F    M    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>	

<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 any additional information below:**

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

Additional Information or Other Medical Conditions that include restrictions on activities:

**Adult Name:** \_\_\_\_\_ **Adult Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**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
- Do you carry an Epi-Pen?              Yes      No
- Do you carry an inhaler?              Yes      No
- Do you have a Special Medical or Dietary Needs?      Yes      No
  - If so, please explain: \_\_\_\_\_
- Have you ever had any adverse reactions to general anesthetics?      Yes      No
  - If so, please explain: \_\_\_\_\_
- Any additional information that we should be made aware of: \_\_\_\_\_

**Medications:** "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. List any medications currently taking including dosage schedule and specific instructions for use. Use an additional sheet if necessary. All medications including OTC must be in original containers and turned into the designated health professional if available. Be sure to include enough of each medication to last the entire event.

Medication	Purpose	Dosage Schedule	Specific Instructions

**OTC – Medications:** In case of emergency or illness please check off all medications that can be given:

OTC Medication Name	OTC Medication Name	OTC Medication Name	OTC Medication Name
Tylenol/Acetaminophen	Pepto Bismol		Skin Ointments – anti-itch/antibacterial
Aspirin	Tums/antacid		Robitussin/expectorant
Ibuprofen	Cough Drops		Sudafed/decongestant
Benadryl/Antihistamine	Imodium		Other

**Health Information Privacy Statement**

The Adult Health History and/or Medical Examination Form is for health care concerns at the specified event only. All records will be managed 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. I understand the information on this form will be shared on a "need to know" basis to provide adequate participant safety and health care. This Health History/Examination Form is complete and accurately reflects the health status of the who it pertains to. In case of an emergency, I give permission to the designated medical staff to treat as necessary for both routine health care and in emergency situations. I also give my permission to secure proper treatment at the hospital/urgent care if necessary. I give permission to photocopy this form. I have read the above procedures for managing this health and medical form and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

**Adult Name:** \_\_\_\_\_ **Adult Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Adult Health History and Medical Examination

**Medical Examination:** This page (3) must be completed by a licensed professional as listed above, once they have reviewed the completed and signed Health History (pages 1 & 2).

<b>Patient Name:</b>		<b>Patient Date of Birth:</b>			
Height		Nose		Musculoskeletal	
Weight		Throat		Appearance	
Pulse		Heart		General Physical State	
BP		Lungs		General Mental State	
Hearing		Skin		Other	
Eyes		Abdomen		Other	

Immunization Record	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, Tetanus, Pertussis (DTaP) or (Tdap)						
Tetanus Booster (Tdap) or (Td)						
Mumps, Measles, Rubella, (MMR)						
Polio (IPV)						
Haemophiles Influenzae Type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	Had chicken pox Date:					
Meningococcal Meningitis (MCV4)						
COVID 19						
Tuberculosis (TB) test	Date:	Negative	Positive			

**Patient Acknowledgement of Non- Immunization**

If the patient has not been fully immunized, please have them sign the following statement: I understand and accept the risks that may come from not being fully immunized and do not hold Girl Scouts of Citrus Council, or any related entities responsible.

Adult Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Does this patient have any physical limitations/conditions which might limit any activity for this event/trip?      Yes      No  
 If yes, please explain: \_\_\_\_\_

Should they limit their participation in swimming or other strenuous activity?      Yes      No  
 If yes, please explain: \_\_\_\_\_

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted. Yes, please initial \_\_\_\_\_

Licensed Physician Name: (Last, First, Middle Initial)	Phone Number:
Address:	City:      St:      Zip:

Signature of Licensed Physician: \_\_\_\_\_ State License Number: \_\_\_\_\_ Date: \_\_\_\_\_