



Health History and Medical Examination Form for Adults

Health History: Please complete this form yearly, anytime there may be an update and before any overnight outings. Please be sure to complete all areas. (Complete pages 1&2) **Please type or write clearly and legibly.**

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 examination is 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)

Name of Adult: (Last, First, Middle Initial)	Date of Birth: (XX/XX/XXXX)	Sex: M F
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:

<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:

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
 • Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Do you carry an Epi-Pen? 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. Use an additional sheet if necessary. All medications including OTC must be in original containers and turned into the designated health professional if available.

Medication	Purpose	Dosage Schedule	Specific Instructions
1.			
2.			
3.			
4.			
5.			

In case of accident or injury. Please select all that I am able to be given.

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

Adult Name: _____ **Adult Signature:** _____ **Date:** _____



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This section is to be completed by a physician after the review of health history. Adult must complete all the information in the Health History to the best of their knowledge and sign before meeting with licensed professional.

Medical Examination

Height: _____	Weight: _____	Pulse Rate: _____	B. P.: ____/____
Sugar: _____	Albumin: _____	Blood Hemoglobin: _____	
Hearing: R ____ L ____	Eyes: With Glasses R 20/____ L 20/____	Without Glasses R 20/____ L 20/____	
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined			
_____ Nose	_____ Abdomen	_____ Urinalysis*	Other: _____
_____ Throat	_____ Hernia	_____ HGB*	_____
_____ Teeth	_____ Genitalia	_____ Appearance/Nutrition	_____
_____ Heart	_____ Skin	_____ General Physical State	_____
_____ Lungs	_____ Musculoskeletal	_____ General Emotional State	_____

*Girls should have this test if she had not had it since entering puberty.

Does this applicant have any conditions which might limit activity for this event/travel/assignment; such as chronic disease, weight or limit participation in swimming or other strenuous activity? Yes No
 If yes, please explain: _____

Record of Immunization

	Date Series was Completed	Year of Last Booster		Date Series was Completed	Year of Last Booster
Hep B	_____	_____	Typhoid	_____	_____
DTap/Tdap	_____	_____	Paratyphoid	_____	_____
DT/Td	_____	_____	Cholera	_____	_____
Hib	_____	_____	Yellow Fever	_____	_____
IPV/OPV	_____	_____	Typhus	_____	_____
PCV7	_____	_____	Rocky Mountain	_____	_____
MMR	_____	_____	Spotted Fever	_____	_____
Varicella	_____	_____	Tuberculin Test: Year last given	_____	Result _____
Other:			Not required immunizations, but recommended		
_____	_____	_____	HPV	_____	_____
_____	_____	_____	Rota	_____	_____
_____	_____	_____	MCV4/MPSV4	_____	_____
_____	_____	_____	Hep A	_____	_____
_____	_____	_____	TIV/LAIV	_____	_____

Physician Information

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

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

Signature of Licensed Physician: _____ **State License Number:** _____ **Date:** _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Adult Health History and Medical Examination Form** 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 and Medical Examination Form is complete and accurate.

Adult Name: _____ **Adult Signature:** _____ **Date:** _____