



ADULT HEALTH HISTORY RECORD

This health history is to be completed and signed by adult members themselves

Sahuaro Girl Scout Council, Inc.
4300 E. Broadway Blvd.
Tucson, AZ 85711
520-327-2288 or 1-800-331-6782
www.sahuarogsc.org

Name		D.O.B.	Age
Address		Troop #	Daytime Phone
City	State	Zip Code	Evening Phone
In Emergency Notify (Name)			Relationship
Address			Daytime Phone
Name of Family Physician			Evening Phone
Family Medical/Hospital Insurance Carrier			Policy or Group #

Part I: Illnesses and injuries (check those that apply and give appropriate dates) Chronic or Recurring Illness

Ear Infection Bleeding/Clotting Disorder Hypertension Asthma
 Heart Defect/Disease Musculoskeletal Disorders Seizures Diabetes
 Other (Specify) _____

Date of last health examination: _____ Were any complicating medical problems noted in last health examination? Yes No

Is participant currently under the care of physician or psychologist? Yes No

Part II: Allergic (check those that apply and specify nature of allergic reaction).

Animals _____ Hay Fever _____ Medicine/Drugs _____
 Pollen _____ Food _____ Insect Stings _____
 Plants _____ Other _____

Part III: Other health conditions (check those that apply)

Emotional Disturbances Sleep disturbances Hearing impairment Sickle cell trait of disease
 Fainting Nosebleeds Menstrual cramps Wears glasses or contact leses
 Motion Sickness Special Dietary Needs
 Other _____

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted. Please attach additional sheet(s) of paper if needed.

This health history is correct and I am able to engage in all prescribed activities except as noted.

Signature of Adult _____ Date _____

Emergency Medical Authorization

PURPOSE: To authorize the provision of emergency treatment for illness or injury while on a Girl Scout activity. I give my consent for emergency medical treatment in the emergency room of the nearest hospital.

Signature of Adult _____ Date _____

Does a Certified First Aider have permission to administer first aid treatment in case of illness or accident? Yes No

Signature of Adult _____ Date _____