girl scouts san diego

Health History
High Adventure / Wilderness Hiking / Backpacking

(To be completed by Parent/Guardian or Adult Participant. **Please use black or blue ink.**)

Participant's name ______________________________ Date of birth ____________ Marital Status__________

Physical address ______________________________ Mailing address______________________________

Daytime phone (_____) ____________ Evening phone (_____)____________ E-mail ______________________

In an emergency notify ______________________________ Relationship ______________________

Daytime phone (_____)____________ Evening phone (_____)____________ E-mail ______________________

Family physician ____________ Phone (_____) ____________ Family dentist ____________ Phone (_____) ____________

Family medical/hospital insurance carrier ______________________ Policy or group # ______________________

In order to better serve the needs of participants in the High Adventure Activity, it is imperative that all medical information is documented below.

Chronic illness
__ Epilepsy/seizures
__ Eating disorder
__ Heart disease
__ Asthma
__ Diabetes
__ Sickle cell anemia
__ Hearing impairment

Other health conditions (check all that apply)
__ Frequent headaches
__ Nosebleeds
__ Stomach upsets
__ Constipation/diarrhea
__ Altitude Sickness
__ Motion sickness
__ Emotional disturbance
__ Menstrual problems
__ Fainting
__ Wears glasses/contacts

For overnights only
__ Sleep walking
__ Night terrors
__ Bed-wetting

__ Recent infections ______________________ __Allergies (specify) ______________________

Date of last health examination: ________________ __ Other (specify) ______________________

Were any complicating medical problems noted? ______________________________

Medication: Is the participant currently taking prescription/over the counter medication? __ Yes __ No

If yes, please explain. ______________________________

Has the participant been on prescription medication within the last three months? __ Yes __ No

If yes, please explain. ______________________________

List past medical treatment such as operations, treatment for serious injuries, diseases or disabilities, hospitalizations and dates: ____________

____

List any key outdoor concerns (*e.g.,* fear of heights, stream crossings, snow): ______________________________

____

Immunization History: Are immunizations up to date? Y ___ N ___ Hepatitis A: Yes ___ No ___ Chicken Pox: Yes ___ No ___

Date of last tetanus shot __________

Is the participant currently:
__ under a physician's care
__ receiving psychological counseling
__ restricted in physical activity

In the last year, has there been incident of:
__ hospital treatment
__ an injury/illness requiring medical attention
__ an illness lasting longer than 5 days
__ a surgical operation or fracture
__ exposure to contagious disease

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to High Adventure Activity events:

____

_____ I have been informed that this trip involves certain risks. I have been made aware of the effects of high altitude and the risks involved with climbing to an altitude of over 8,000 feet. I have read the materials provided regarding altitude risks and sickness and approve my minor child to participate in this activity. **(Must be initialed for all girls and adults participating in high altitude climbing.)**

This health history is complete and accurate. I know of no reason(s) other than the information indicated on this form, why my minor child/I should not participate in a High Adventure Activity (Wilderness Hiking/Backpacking Beginning or Advanced/Rock Climbing, etc.). If any incident occurs that may have impact on the health or safety of my child/myself while participating in High Adventure Activity, I will notify the leader in charge in advance of the event. I understand that this event may take place more than 2 hours from definitive medical care and that it may be necessary to provide emergency attention before medical help arrives.

As the parent of a minor participant, I give my permission for the adult in charge to take my child to a medical facility for treatment. As an adult participant, I give my permission to be taken to a medical facility for treatment. In case of emergency, if none of the above can be contacted, I, the undersigned, consent to allowing treatment under the supervision of and as deemed advisable by a physician licensed under the Medicine Practice Act. This provides authority pursuant to Section 25.8 of the California Civil Code.

Parent of Minor/Adult Participant signature ______________________________ Date ______________

A new High Adventure Health History form must be completed every two years. If this is the 2nd year, please check, date and initial your option:
_____ I have reviewed the above information and there are no changes in my health history (initial and date) ______________
_____ I have made changes above to reflect my current health history (initial and date) ______________

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