girl scouts san diego

Adult Health History Record

(To be completed and signed by the adult--the information will be kept confidential.)

Name		**Date of birth**
Address		**City and Zip**
Daytime phone	**Evening phone**	**Cell phone**
In emergency notify		**Relationship**
Daytime phone	**Evening phone**	**Cell phone**
Name of physician		**Phone**
Name of dentist		**Phone**

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

☐ Ear infection ☐ Bleeding/clotting disorders ☐ Hypertension ☐ Asthma ☐ Other (specify)

☐ Heart defect/disease ☐ Musculoskeletal disorders ☐ Seizures ☐ Diabetes _____

Date of last health examination: _____ Please note any complicating medical problems determined in last health examination:

_____

_____

Is participant currently under the care of a physician, psychiatrist or psychologist? ☐ Yes ☐ No

Since last health exam has participant had:	**Yes**	**No**
A serious injury requiring medical attention?	☐	☐
Any prescribed or over-the-counter medication?	☐	☐
Treatment in a hospital or emergency room?	☐	☐
Any exposure to a contagious disease?	☐	☐
An illness lasting more than five days?	☐	☐
A surgical operation or fracture?	☐	☐
Any restrictions concerning physical activities?	☐	☐

Please explain any "yes" answers to these questions. Include dates.

_____

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No

If yes, what is the allergy? _____

What is the reaction? _____

Other health conditions (check those that apply)

☐ Emotional disturbances
☐ Constipation
☐ Menstrual cramps
☐ Nosebleeds
☐ Sleep disturbances
☐ Motion sickness
☐ Other _____
☐ Fainting
☐ Hearing impairment
☐ Sickle cell trait/disease
☐ Special dietary regimen
☐ Wear glasses or contacts

Immunization History

Are all immunizations current? ☐ Yes ☐ No

If not, explain:

_____

_____

_____

Date of last Tetanus _____

Do you smoke? ☐ Yes ☐ No

Do you take medication that might impair your ability to perform the essential functions of your job? ☐ Yes ☐ No

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 restricted.

_____

_____

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

_____

_____

In case of emergency, if none of the above can be contacted, I consent to treatment for myself 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. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Signature _____ Date _____