GIRL & ADULT HEALTH HISTORY RECORD

This health history is to be completed and signed by parents/guardians
Of girls or by adult members themselves.

Name	Date of Birth	Age
Address	Troop #	
Parent/Guardian	(Area Code) Phone	
Home Address		
Business Address	(Area Code) Phone	
In Emergency Notify Name	Relationship	
Address	(Area Code) Phone	
Name of family physician:	(Area Code) Phone	
Family medical/hospital insurance carrier:	Policy or Group No.	

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

- ☐ Ear Infection ☐ Bleeding/Clotting Disorders ☐ Hypertension ☐ Asthma ☐
- ☐ Heart Defect/Disease ☐ Musculoskeletal Disorders ☐ Seizures ☐ Diabetes ☐ Other (specify) ______

Date of last health examination: ______
Were there any complicating medical problems noted in last health examination? ______
Is participant currently under the care of a physician or psychologist? ______

Since last health exam, has participant had:

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 the above questions. Include dates: ______

MBR318_10

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Part II: Allergies (Check those that apply and specify nature of allergic reaction.)

___ Animals ________ ___ Hay fever
___ Pollen ________ ___ Food ________
___ Medicines/drugs ________ ___ Insect stings ________
___ Plants ________ ___ Other (specify) ________

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

___ Bed wetting ___ Emotional disturbances
___ Constipation ___ Fainting
___ Menstrual cramps ___ Hearing impairment
___ Motion sickness ___ Sickle cell trait or disease
___ Nosebleeds ___ Special dietary regimen
___ Sleep disturbances ___ Wears glasses or contact lenses
___ Other (specify) ________

Part IV: Immunization History

Immunization	Year Primary Series Completed	Year of Last Last Booster
D.T.P.		
Diphtheria		
Pertussis		
Tetanus		
Measles		
Mumps		
Rubella		
Oral polio		
Hib		
Hepatitis B		
Tuberculin test (most recent)		result
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.

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

Signature of parent/guardian ________ Date ________

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

Signature of adult ________ Date ________

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Signature of adult ________ Date ________

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