Girl Scout Council of the Nation's Capital
4301 Connecticut Avenue, N.W. Washington, D.C. 20008
Phone: 202-534-3776 Fax: 202-274-2161

Adult Health History / Emergency Medical Authorization Form

Return completed form to troop/group leader at or before your first troop meeting.

Adult's Name (first, middle, last) _____ Position _____

Home Address _____ City _____ State _____ ZIP _____

Phone 1 _____ Phone 2 _____ E-mail _____

Emergency Contact: _____ Relationship _____

Phone 1 _____ Phone 2 _____ E-mail _____

Emergency Contact: _____ Relationship _____

Phone 1 _____ Phone 2 _____ E-mail _____

Sex: ☐ Female ☐ Male Optional: Date of Birth: _____ Age _____ Current Weight _____ Current Height _____

Health History: (Check all that apply and give approximate dates. Use continuation page as necessary)

☐ ADD/ADHD	☐ Epilepsy	☐ Muscle Disease/Disorder	Wears: ☐ Contacts ☐ Glasses
☐ Arthritis	☐ Fainting	☐ Nervous System Disorder	**Allergies:**
☐ Asthma	☐ German Measles	☐ Pregnant	☐ Animals
☐ Athletes Foot	☐ Hay Fever	☐ Sickle Cell Anemia	☐ Bee/Wasp Stings
☐ Bleeding/Clotting Disorders	☐ Headaches/Migraines	☐ Sinusitis	☐ Plants, Ivy/Oak
☐ Bronchitis	☐ Hearing	☐ Skeletal Disease/Disorder	☐ Drugs
☐ Cancer	☐ Heart Defect/Disease	☐ Skin Conditions	☐ Foods
☐ Chicken Pox	☐ Hypertension	☐ Sleep Disturbance/Walking	☐ Other
☐ Colds/Sore Throats	☐ Kidney Disease	☐ Stomach Upsets	☐ Other
☐ Constipation	☐ Mononucleosis	☐ Urinary Tract Infections	☐ Other
☐ Convulsions	☐ Motion Sickness	☐ Other	
☐ Diabetes	☐ Mumps	☐ Other	
☐ Ear Infections			

Girl Scout Council of the Nation's Capital
4301 Connecticut Avenue, N.W. Washington, D.C. 20008
Phone: 202-534-3776 Fax: 202-274-2161

Adult Health History / Emergency Medical Authorization Form (Page 2)

Please explain any specific needs or accommodations required:_____

Please explain any psychiatric counseling or hospitalization:_____

Please explain and operations or serious injuries:_____

Please explain any disabilities or chronic or reoccurring illness:_____

Please explain any activities to be discouraged by your physician:_____

Please explain dietary modifications:_____

Since last health exam have you had: ☐ a serious injury requiring medical attention? _____ ☐ an illness lasting longer than one week? _____ ☐ an in-patient hospital treatment or the emergency room? _____ ☐ been restricted from participating in any activities? _____

(Please explain any "YES" answers to the above questions and include dates and/or details. May use continuation page if necessary.)

Immunization History: Are all immunizations up-to-date? ☐ Yes ☐ No If no, please state reason _____

Give dates for person listed above. Complete other information as requested.

DTP or DT (Tetanus) Date: _____ Results:_____ Date of last health exam:_____

Insurance Information: Company: _____ Policy #: _____ Date of last health exam:_____

Company Address: _____ City:_____ State: _____ Zip: _____

Other: Name of Dentist/Orthodontist _____ Phone_____

Name of Physician: _____ Phone: _____

Preferred Medical Facility: _____ Location: _____

Medication Information: Any prescribed medication being taken? ☐ No ☐ Yes ☐ Inhaler ☐ Epipen ☐ Other – What, why, when and dosage: _____

IMPORTANT – THIS SECTION MUST BE COMPLETED

This health history is correct so far as I know. I can engage in all activities except as noted. I hereby give permission to the First Aider or Adult in charge to provide routine health care and administer prescribed medications. I consent to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my participation in any activity sponsored by GSUSA, GSCNC or individual units. Should a medical emergency arise during my participation in a Girl Scout-sponsored activity, I understand that reasonable efforts will be made to contact my designated alternate at the phone numbers I have given. If it is believed my life or health may be adversely affected by the delay that an attempt to contact my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied for trips and camping outside of the normal meeting place.

_____ _____

Signature Date

Girl Scout Council of the Nation's Capital
4301 Connecticut Avenue, N.W. Washington, D.C. 20008
Phone: 202-534-3776 Fax: 202-274-2161

Adult Health History / Emergency Medical Authorization Form (continuation page)

Use this page to enter any information that did not fit on pages 1 or 2 of this form.