



# GIRL & ADULT HEALTH HISTORY RECORD

This health history is to be completed and signed by parent/guardian of girls or by adult members themselves.

This is a confidential document. Information should only be share on an as needed basis.

Name	Date of Birth	Age
Address	City/Zip	Troop/Group Number
Parent/Guardian	(Area Code) Phone	Cell Phone
Home Address		
Business Address	(Area Code) Phone	Cell Phone
In Emergency Notify: Name	Relationship	
Address	(Area Code) Phone	Cell Phone
Name of family physician:	(Area Code) Phone	
Family medical/hospital insurance carrier:	Policy or Group Number	

## Part I: Illnesses and Injuries (Check those that apply and give appropriate dates)

### Chronic or Recurring Illness

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Bleeding/Clotting Disorders | <input type="checkbox"/> Hypertension              |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Heart Defect/Disease        | <input type="checkbox"/> Musculoskeletal Disorders |
| <input type="checkbox"/> Seizures      | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Hypoglycemia              |

Other (specify) \_\_\_\_\_

Date of last health examination: \_\_\_\_\_

Were any complicating medical problems noted in last health examination? \_\_\_\_\_

Is participant currently under the care of a physician or psychologist? \_\_\_\_\_

Is participant currently taking any prescription medication? \_\_\_\_\_

Since last health exam, has participant had:

- a serious injury requiring medical attention? \_\_\_\_\_
- an illness lasting more than five days? \_\_\_\_\_
- any prescribed or over-the-counter medication? \_\_\_\_\_
- a surgical operation or fracture? \_\_\_\_\_
- treatment in a hospital or emergency room? \_\_\_\_\_
- any restrictions concerning physical activities? \_\_\_\_\_
- any exposure to a contagious disease? \_\_\_\_\_

Please explain any "yes" answers to the above questions. Include dates: \_\_\_\_\_

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

<input type="checkbox"/> Animals	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Pollen	<input type="checkbox"/> Food
<input type="checkbox"/> Medicines/drugs	<input type="checkbox"/> Insect stings
<input type="checkbox"/> Plants	<input type="checkbox"/> Other (specify) _____

**Part III: Other health conditions** (Check those that apply and specify nature of allergic reactions.)

<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Emotional disturbances
<input type="checkbox"/> Constipation	<input type="checkbox"/> Fainting
<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Hearing impairment
<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Sickle cell trait or disease
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Special dietary regimen
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Wear glasses or contact lenses
<input type="checkbox"/> Attention deficit disorder	<input type="checkbox"/> Other (specify) _____

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. \_\_\_\_\_

**Part IV: Immunization History**

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P.	_____	_____
Diphtheria	_____	_____
Tetanus	_____	_____
Pertussis (Whooping Cough)	_____	_____
Td	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella (German Measles)	_____	_____
Oral Polio	_____	_____
Hib	_____	_____
Hepatitis B	_____	_____
Tuberculin Test (most recent)	_____ Result	_____
Other _____	_____	_____

This health history is completed and accurate. I know of no reason(s) 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 \_\_\_\_\_