Girl Scouts of the Green and White Mountains
Health History and Medical Examination Form for Adults

Health History: The more complete information you provide, the better we can work with you to ensure you receive the care you need.

Medical Examination: A medical examination is completed for trips lasting more than three nights. The examination is completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months unless a health issue is present.

Please type or write clearly and legibly.

Name of Adult: (Last, First, Middle Initial)	**Date of Birth:** (XX/XX/XXXX)		**Gender:**
Address:	**City:**	**St:**	**Zip:**
Spouse (if applicable):	**Phone:**	**Alternate Phone:**	

Emergency Contact Information:

Emergency Contact:	**Relationship:**
Phone:	**Alternate Phone:**

Health Insurance Information (Family insurance is primary insurance in case of accident or illness; Girl Scout insurance is secondary.)

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply and explain in detail checked answers:

	Diabetes
	Heart Defects/Disease
	Asthma or Hay Fever
	Diseases of the Ears or Ear Infections
	Musculoskeletal Disorders
	Convulsions/Epilepsy/Seizures
	Sinusitis (Sinus Infections)

	Eyesight Impairment
	Hearing Impairment
	Speech Impairment
	Intestinal Disorders/Constipation
	Chicken Pox
	Measles
	German Measles

	Physical Restrictions			Mumps
	Kidney/bladder illness			Rheumatic Fever
	Mental/psychological disorder			Tuberculosis
	Hypertension/Abnormal Blood Pressure			Kidney Disease
	Arthritis			Eating Disorders (Anorexia, Bulimia, etc.)
	Nosebleeds			Headaches/Migraines
	Hernia			Had surgery or hospitalized in the last 5 years
	Menstrual cramps			Currently under doctor's care
	Bleeding disorder			Other: _____

Please explain in detail all checked answers marked above:

Allergies: Please list all allergies, the type of reaction and its severity, treatment, and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Do you suffer from Anaphylaxis? Yes No

*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Do you carry an EpiPen? Yes No

Do you carry an inhaler? Yes No

Medical Conditions (Include any precautions or restrictions on activities.)

Name of Condition	Effects
1.	
2.	
3.	

Medications: List any medications currently taken (or has taken in the recent past) including dosage schedule and specific instructions for use.

Medication	Purpose	Dosage Schedule	Specific Instructions
1.			
2.			
3.			
4.			
5.			

Over-the-Counter Medications: In case of accident or injury. Please check all that apply:

- ☐ Tylenol/Acetaminophen
- ☐ Aspirin (fever reducer)
- ☐ Ibuprofen (pain/swelling)
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/expectorant
- ☐ Sudafed/decongestant
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Imodium (anti-diarrhea)
- ☐ Dramamine (motion sickness prevention)
- ☐ Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
- ☐ Other: _____
- ☐ Other: _____

Special considerations or notes regarding over-the-counter medications:

Do you have a Special Medical or Dietary Regiment to be followed? Yes No

If so, please explain: _____

Have you ever had any adverse reactions to general anesthetics? Yes No

If so, please explain: _____

Additional information that is important for other advisors on this trip to know about: _____

_____

Adult Name: _____ **Date:** _____

This next section is to be completed by a physician after the review of health history. Adult must complete all the information in the Health History to the best of their knowledge and sign before meeting with licensed professional.

Medical Examination

Height: _____ Weight: _____ Pulse Rate: _____ B. P.: _____/_____

Sugar: _____ Albumin: _____ Blood Hemoglobin: _____

Hearing: R ___ L ___

Eyes: With Glasses R 20/_____ L 20/___ Without Glasses R 20/____ L 20/____

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

_____ Nose	_____ Abdomen	_____ Urinalysis*	Other: _____
_____ Throat	_____ Hernia	_____ HGB*	_____
_____ Teeth	_____ Genitalia	_____ Appearance/Nutrition	_____
_____ Heart	_____ Skin	_____ General Physical State	_____
_____ Lungs	_____ Musculoskeletal	_____ General Emotional State	_____

*Girls should have this test if she had not had it since entering puberty.

Does this applicant have any conditions which might limit activity for this event/travel/assignment; such as chronic disease, weight or limit participation in swimming or other strenuous activity? Yes No

If yes, please explain: _____

Record of Immunization

	Date Series was Completed	Year of Last Booster		Date Series was Completed	Year of Last Booster
Hep B	_____	_____	Typhoid	_____	_____
DTap/Tdap	_____	_____	Paratyphoid	_____	_____
DT/Td	_____	_____	Cholera	_____	_____
Hib	_____	_____	Yellow Fever	_____	_____
IPV/OPV	_____	_____	Typhus	_____	_____
PCV7	_____	_____	Rocky Mountain		
MMR	_____	_____	Spotted Fever	_____	_____
Varicella	_____	_____	Tuberculin Test: Year last given	_____	Result _____
Other:			Not required immunizations, but recommended		
_____	_____	_____	HPV	_____	_____
_____	_____	_____	Rota	_____	_____
_____	_____	_____	MCV4/MPSV4	_____	_____
_____	_____	_____	Hep A	_____	_____
_____	_____	_____	TIV/LAIV	_____	_____

Physician Information

Licensed Physician Name: (Last, First, Middle Initial)	**Phone Number:**		
Address:	**City:**	**St:**	**Zip:**

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

Signature of Licensed Physician: _____

State License Number: _____ **Date:** _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Adult Health History and Medical Examination Form** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years in the case of treatment. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Adult Health History and Medical Examination Form is complete and accurate.

Signature of Adult Participant: _____ **Date:** _____