girl scouts of southern illinois

Adult Health History

Health History: The more complete information you provide, the better we are able to 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.

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

Emergency Contact Information:

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

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 (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Adult Name: _____

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.			

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 to know about:

_____

_____

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 member: _____ **Date:** _____

I understand that as with any social activity, use of council facilities or services, or participation in council programs, may present the risk of contracting COVID-19. While council takes safety and preventative precautions, council can in no way warrant that COVID-19 infection will not occur through use of such facilities or services or participation in council programs. The undersigned assumes the risk of contracting COVID-19 and any of its variants. I understand that I will be responsible for following any and all safety measures in place at the time as required by local and state mandates and/or the facility hosting the activity.

☐ **YES** ☐ **NO** **Initials**_____