

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	Policy or Group No.	
carrier: Part I: Illnesses and injuries (check those that apply and give appropriate dates) Chronic or Recurring Illness		
	Asthma	
	Diabetes Other (specify)	
Date of last health examination:	Diabetes Other (specify)	-
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? An illness lasting mo	ro than five days?	
Any prescribed or over-the-counter medication? Any prescribed or over-the-counter medication? Assurgical operation		
Treatment in a hospital or emergency room? Any restrictions conc	erning physical activities?	
Any exposure to a contagious disease?		
Please explain any "yes" answers to the above questions. Include dates:		
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	rents/guardians	
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Part II: Allergies (Check the	ose that apply and specify nature of	Part IV: Immunization Histo	ry	
allergic reaction.)		Immunization	Year Primary	Year of Last
			Series Completed	Last Booster
Animals	Hay fever	D.T.P.	·	
Pollen	Food	Diphtheria		
Medicines/drugs	Insect stings	Pertussis		
Plants	Other (specify)	Tetanus		-
Fiants	Other (specify)	retarius		
B	(2)			
	tions (Check those that apply)	Measles		
Bed wetting	Emotional disturbances	Mumps		
Constipation	Fainting	Rubella		
Menstrual cramps	Hearing impairment	Oral polio		
Motion sickness	Sickle cell trait or disease	Hib		
Nosebleeds	Special dietary regimen	Hepatitis B		·
Sleep disturbances	Wears glasses or contact lenses	Tuberculin test (most recent)	result	·
Other (specify)	_	Other		
	t are checked. Indicate any information u	seful to the adult in charge in relat	ion to any of these healt	n conditions. Also,
indicate any activities to be e	ncouraged or restricted.			
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			1 11:6	
	te and accurate. I know of no reason(s), of	other than the information indicate	a on this form, why my a	aughter should not
participate in prescribed activ	rities except as noted.			
Signature of parent/guardian			Date	
This health history is complet	te and accurate. I am able to engage in a	Ill prescribed activities except as n	oted.	
,				
Signature of adult			Date	
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Part II: Allargias (Chack that	ose that apply and specify nature of	Part IV: Immunization Histo	rv	
	ose that apply and specify nature of	Part IV: Immunization Histo		Voor of Loct
Part II: Allergies (Check the allergic reaction.)	ose that apply and specify nature of	Part IV: Immunization Histo Immunization	Year Primary	Year of Last
allergic reaction.)		Immunization		Year of Last Last Booster
allergic reaction.) Animals	Hay fever	Immunization D.T.P.	Year Primary	
allergic reaction.)		Immunization	Year Primary	
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