



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 carrier:	Policy or Group No.	

Part I: Illnesses and injuries (check those that apply and give appropriate dates)

Chronic or Recurring Illness

- Ear Infection
 Bleeding/Clotting Disorders
 Hypertension
 Asthma
 Heart Defect/Disease
 Musculoskeletal Disorders
 Seizures
 Diabetes
 Other (specify) _____

Date of last health examination: _____

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 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: _____

MBR318_10



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Any exposure to a contagious disease? _____

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

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Part II: Allergies (Check those that apply and specify nature of allergic reaction.)		Part IV: Immunization History		
		Immunization	Year Primary Series Completed	Year of Last Last Booster
<input type="checkbox"/> Animals	<input type="checkbox"/> Hay fever	D.T.P.		
<input type="checkbox"/> Pollen	<input type="checkbox"/> Food	Diphtheria		
<input type="checkbox"/> Medicines/drugs	<input type="checkbox"/> Insect stings	Pertussis		
<input type="checkbox"/> Plants	<input type="checkbox"/> Other (specify) _____	Tetanus		
Part III: Other health conditions (Check those that apply)		Measles		
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Emotional disturbances	Mumps		
<input type="checkbox"/> Constipation	<input type="checkbox"/> Fainting	Rubella		
<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Hearing impairment	Oral polio		
<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Sickle cell trait or disease	Hib		
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Special dietary regimen	Hepatitis B		
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Wears glasses or contact lenses	Tuberculin test (most recent)	_____ result	
<input type="checkbox"/> Other (specify) _____		Other		

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.

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, 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 _____

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