

Girl/Adult Health History Form

This form must accompany an adult at every event/activity. Information should be updated on a regular basis.

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Troop #: or _ Individual Service Unit:	☐ Girl Member	□ Adult Member		
Mailing Address:	Troop #: or □ Ind	dividual Service Unit:		
City: State: Zip: Daytime Phone: () Cell Phone: () E-mail:	First Name:	Middle:	Last Name	e:
Daytime Phone: () Cell Phone: ()	Mailing Address:		Apt #:	P.O. Box:
1. Parent/Guardian Name (Complete for Girl Form Only):	City:	State:	Zip:	
Phone: () Cell Phone: ()	Daytime Phone: ()	Cell Phone: ()	E-mail:	
2. Parent/Guardian Name (Complete for Girl Form Only):	 Parent/Guardian N 	lame (Complete for Girl Form Only	/):	
Phone: () Cell Phone: () Phone: ()	Phone: ()	Cell Phone: ()		
Name of Family Physician: Phone: (
Family Medical/Hospital Insurance Carrier:				
Family Dental Insurance Carrier:				
Health Information Age: Immunizations up to date? Y N Date of Last Tetanus Shot:				
Age: Immunizations up to date?		rier:	Policy/Grou	up#:
Date of Last Tetanus Shot: / / Date of Last Heath Examination: / / Were there any medical problems at the time (if yes, explain)?			-	
Date of Last Heath Examination: / / Were there any medical problems at the time (if yes, explain)?		·	UY UN	
Were there any medical problems at the time (if yes, explain)?		· · ·		
Has participant had any recent injuries or surgeries?				
If yes, please explain and specify date: Does participant take any prescribed medications on a regular basis?	•			
Does participant take any prescribed medications on a regular basis?		-		
If yes, please state medication and reason: Is participant restricted or limited from participating in any physical activity?		·		
Is participant restricted or limited from participating in any physical activity? \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				
If yes, please explain:	, ,,			
Participant has the following health conditions/allergies (food and medications): ADHD Asthma Diabetes Headaches Seizures Other: Allergies (specify): Emergency Contact (non-parent): Cell Phone: () Emergency Contact (non-parent): Cell Phone: () Emergency Contact (non-parent): Cell Phone: () Phone: () Cell Phone: () Parent/Guardian Authorization: Lectify that this health form 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 the prescribed activities except as noted In the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Michigan Shore to Shore to seek treatment for my child and/or dependent minor by a licensed physician pursuant to the Michigan Child Care Licensing Act 116 of 1973, Section 14a. Signature of Parent/Guardian: Date: Adult Member Authorization: Lectify that this health history is complete and accurate. I am able to engage in all prescribed activities except as noted.				
ADHD Asthma Diabetes Headaches Seizures Other:				
Allergies (specify):				
Emergency Contact (non-parent):	☐ ADHD ☐ Asti	hma 🗖 Diabetes 🗖 Headach	es 🛭 Seizures 🚨 Ot	ther:
Phone: () Cell Phone: () Relationship: Relationship: Phone: () Cell Phone: () Relationship: Relationship: Phone: () Cell Phone: () Parent/Guardian Authorization: I certify that this health form 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 the prescribed activities except as noted. In the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Michigan Shore to Shore to seek treatment for my child and/or dependent minor by a licensed physician pursuant to the Michigan Child Care Licensing Act 116 of 1973, Section 14a. Signature of Parent/Guardian: Date:				
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Phone: () Cell Phone: () Parent/Guardian Authorization: I certify that this health form 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 the prescribed activities except as noted In the event of an emergency, every effort will be made to contact a parent/guardian or emergency contact. If no contact can be made, I hereby give authorization to Girl Scouts of Michigan Shore to Shore to seek treatment for my child and/or dependent minor by a licensed physician pursuant to the Michigan Child Care Licensing Act 116 of 1973, Section 14a. Signature of Parent/Guardian:				
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Signature of Adult Member: Date: Date:			engage in all prescribed activ	ities except as noted.
	Signature of Adult Member:		_ Date:	