



Adult Health History

To be completed and signed by adult

Section 1 - Health History

Section 2 – Extended Travel (3+ Days) Health Form

Section 3 – Extended Travel (3+ Days) Physician Exam

Adult Full Name:	Date of Birth:	Age:
Address:		
Phone:	Email:	
Physician's Name:	Phone:	
Emergency Contact:	Phone:	Relationship:

Medical History - Check all that apply

<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Fainting/dizzy spells	<input type="checkbox"/>	Menstrual cramps
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	Musculoskeletal Disorders
<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	Mental/Psychological Disorders
<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	Speech Impairment	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	Convulsions/Epilepsy/ Seizures	<input type="checkbox"/>	Heart Defects/Disease	<input type="checkbox"/>	Sinusitis (Sinus Infections)
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Sleep Disturbances
<input type="checkbox"/>	Diseases of the Ear or Ear Infections	<input type="checkbox"/>	Hypertension/High Blood Pressure	<input type="checkbox"/>	Sleep Impairment
<input type="checkbox"/>	Eating Disorders (Anorexia, Bulimia, etc.)	<input type="checkbox"/>	Intestinal Disorders/Constipation	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Eyesight Impairment	<input type="checkbox"/>	Kidney/bladder illness	<input type="checkbox"/>	
<input type="checkbox"/>	Currently Under Physician/Psychologist care	<input type="checkbox"/>	Had Surgery/Hospitalized in the last 5 years	<input type="checkbox"/>	

Date of last health examination: _____

Were any complicating medical problems noted in the last health exam: Yes No

Please explain in detail any items checked above:

Are all immunizations current? Yes/ No If not, state reason(s):

DTP or DT (Tetanus) Date:

Allergies - List ALL allergies (including medications, food, bees, etc.), the type of reaction/severity, treatment and date of last reaction.

Allergies	Reaction/Severity	Treatment	Date of Last Reaction

Comments:

Do you suffer from anaphylaxis?* Yes No

*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

Prescribed Medications - I take the following medications.			
Medication	Purpose	Dosage	Special Instructions
Other:			
Special considerations or notes:			

Over the Counter Medications & Dietary Restrictions			
	I do not take over the counter medication (please include over the counter medication allergies above).		
	I can take the following over the counter medications daily or in case of accident/injury/sickness (for example pain reliever, digestive relief, etc.). Please include dosage as necessary.		
Special consideration or notes:			
I have the following dietary restrictions:			

Health Insurance Information (In case of accident or illness, personal insurance is primary, Girl Scout insurance is secondary)			
Policy Holder Name		Insurance Company	
Policy Number		Insurance Company Address	
Group Number		Insurance Company Phone Number	

Initial and Sign

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact, by contact with contaminated surfaces and objects, and possibly in the air. People reportedly can be infected and spread the disease even if they do not show any symptoms. Girl Scouts of Western Washington (“GSWW”) is committed to taking precautions to mitigate that risk as well as to following applicable federal, WA State, local and GSUSA COVID-19 directives and guidelines. Our council is also committed to having in-person activities as allowed and in accordance with those mandates. GSWW’s operations and programs occurring while COVID-19 is circulating in our community may expose our members, volunteers, and employees to the risk of infection. GSWW cannot prevent you from becoming exposed to, contracting or spreading COVID-19 while attending (which includes being present in any capacity) any GSWW in-person programming. Therefore, any interaction with others in connection with in-person programming may expose you and your family to and increase your risk of contracting or spreading COVID-19. GSWW has put in place preventative measures to reduce the spread of COVID-19 at its in-person programming; however, GSWW cannot guarantee that you will not become infected with COVID-19.

By participating in these in-person activities, participants will be viewed as: 1.) Understanding that COVID-19 is a highly contagious virus, easily spread including through in-person contact; 2.) Acknowledging that GSWW cannot guarantee that infection will not occur; 3.) Choosing to accept the risk of contracting COVID-19 for the participant and their family in order to attend the in-person activity; and 4.) Agreeing to release GSWW from responsibility in the event of COVID-19 infection. Participants who do not agree to these statements should not join in-person GSWW activities.

Initial:

This health history is correct and I am able to participate in all prescribed activities except as noted.

Signature:

Date:

Section 2 – Extended Travel (3+ Days) Health Form – to be completed by Adult

Secondary Emergency Contact			
Name		Phone	
Relationship		Secondary Phone	
Email			

Additional Medical History			
Check all that apply			
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Measles	<input type="checkbox"/>	Other:
Please explain in detail any items checked above:			

Medical Conditions and/or Concerns	
Please include any precautions or restrictions on activities, as well as concerns relating to emotional and mental well-being (including self-harm, depression, effects of medication on their behavior, eating disorders, etc.). We want to provide the most supportive environment possible, and a large part of that is knows what's going on with trip participants. The more information you provide, the better we can to work with you to establish a plan.	
Name of Condition	Effects
Additional Information or Comments:	
Have you had any adverse reactions to general anesthetics? Yes No	

Adult Name _____

Adult Name _____

Section 3—Extended Travel (3+ Days) Health Examination Form – to be completed by Physician

Trip Information - Must be completed by Adult	
Trip/Activity:	
Region/Location:	Date Range of Trip/Activity:
Distance from Emergency Medical Services:	Level of First Aid Required:
Trip/Activity Description: Include a brief description of your trip. This will help the medical professional evaluate your physical readiness for the trip. Please note if different activities will be done (ex. rock climbing, cultural sites, etc.)	

Record of Immunization - Complete in detail or attach documentation					
Immunization	Date Series Completed	Year of Last Booster	Immunization	Date Series Completed	Year of Last Booster
Hepatitis B			Hepatitis A		
Diphtheria, Tetanus, Pertussis (DTap/Tdap)			Inactivated Poliovirus (IPV)		
Measles, Mumps, Rubella (MMR)			Influenza		
Rotavirus (RV)			Varicella		
Haemophilus influenzae type b (Hib)			Meningococcal (MCV)		
Pneumococcal (PCV)			Human Papillomavirus (HPV)		
IPV/OPV			Typhoid		
Paratyphoid			Cholera		
Yellow Fever			Typhus		
Rocky Mountain			Spotted Fever		
Rota			Other		
Tuberculin Test Year last given:			Results:		

Medical Examination Form - Must be completed by a licensed physician, nurse practitioner, physician assistant or registered nurse within the preceding 12-24 months, unless a health issue is present.

Height:	Weight:	Blood pressure:	Pulse Rate:
Hearing: R: L:	Eyes: With Glasses R 20/ L20/	Eyes: Without Glasses R 20/ L20/	

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

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

Licensed Physician Name: _____ State License Number: _____
 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. Yes No

Signature of Licensed Physician: _____ Date: _____