

GIRL SCOUTS OF GLOWING EMBERS COUNCIL, INC
CONFIDENTIAL GIRL/ADULT HEALTH HISTORY

Complete all information on both sides of the form. Print clearly, please. For questions contact the Kalamazoo Program and Training Center at 269-343-1516 or 800-788-4919.

Name _____ Troop # _____ S.U. _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Emergency Contact:

1. Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

2. Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Primary Health Care Provider: _____

Name of Principal Person Carrying Insurance _____

Health Insurance Policy Number _____ Employer _____

Family Physician: _____ Phone: _____

Address: _____ Date of last exam _____

Immunization Record (Indicate Date): Tetanus _____ Hepatitis B _____ TB _____

Chronic Illness and Conditions:

Asthma Heart Defect/Disease Seizures
 Bleeding/Clotting Disorder Hypertension Upper Respiratory
 Diabetes Infectious/Communicable Disease Chronic Illness
 Chronic Infection Other (explain): _____

Other Health Conditions:

Glasses/Contact Lenses Hearing Impairment Visual Impairment
 Pregnancy (Due Date) _____ Physical Disability Other _____

Please explain any checked illness or condition(s):

Allergies:

Insects Food Medication Other _____
Do you carry medication for your allergies? YES NO
If YES, please explain how it should be administered.

Medication Used Regularly:

Name	Dosage/Frequency	Purpose/Diagnosis
_____	_____	_____
_____	_____	_____

Please describe any restrictions or limitations:

Please indicate any additional information that would be useful to a First Aider or other medical personnel regarding any of the above indicated health conditions.

Emergency Medical Release for GIRLS (under 18 years)

I consent for my daughter, _____, to receive emergency medical care. In case of emergency, I hereby give permission to the licensed physician selected by the troop/group/event leader to hospitalize my daughter and secure medical/surgical treatment if I, or the other emergency contacts, are unable to be reached.

Parent Signature

Date

Emergency Medical Release for ADULTS (18 years or older)

I consent to medical care in an emergency. In case of emergency, I hereby give permission to the licensed physician selected by the troop/group/event leader to hospitalize me and secure medical/surgical treatment if I am incapacitated and my emergency contact(s) are unable to be reached.

Signature

Date