

GIRL SCOUTS OF SAN FRANCISCO BAY AREA
ADULT HEALTH HISTORY RECORD

ALL INFORMATION TO BE COMPLETED AND SIGNED BY ADULT ANNUALLY

PART I: ADULT RECORD

Camp, Program, or Event Name		Position		
Adult's Name		Birth Date	Sex	E-Mail Address (For GSSFBA use only)
Address	City/State	Zip Code	Home Phone ()	Work Phone ()

This information is needed to measure how well your council is serving the Bay Area's diverse population, it will be combined with everyone in the troop/program/event without identifying anyone individually.

Racial background: (please check as many as apply) American Indian or Alaskan Native Asian
 Black or African American Hawaiian or Pacific Islander White Other (specify) _____
Ethnic background: (please check one) Hispanic or Latino Not Hispanic or Latino

WRITTEN PERMISSION NEEDED: Adult must have written permission from a licensed physician for adult to participate in program if adult has a known complicating medical problem or has had an operation or serious illness since the last health exam.

I hereby give permission to the physician, selected by the council to render emergency medical/surgical treatment on my behalf.

Signature: _____ Date: _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Adult Health History Record** is for health care concerns at the specified events only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the sponsoring council until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature (Adult participant): _____ Date: _____

PART II: EMERGENCY CONTACT

Name:		Relationship:		
Address	City	State	Zip	Day Phone ()
				Evening Phone ()

PART III: HEALTH HISTORY

Allergic Reaction (Check those that apply and specify nature of allergic reaction) **Check here for no known allergies**
 Animals _____ Hay Fever _____ Medicines/Drugs _____ Pollen _____
 Food _____ Insect Stings _____ Plants _____ Other (specify) _____

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates) **Other Chronic/Recurring Illnesses (specify)** _____
 Arthritis _____ Diabetes _____ Fainting _____ Menstrual Problems _____
 Asthma _____ Dizziness _____ Heart Defect/Disease _____ Musculoskeletal Disorder _____
 Bleeding/Clotting Disorders _____ Ear Infection _____ Hypertension _____
 Seizures _____

Other Health Conditions: (Check those that apply) **Other (specify):** _____
 Chicken Pox Emotional Disturbances Lyme Disease Sickle Cell Trait/Disease Visual Impairment
 Contact Lenses Glasses Motion Sickness Sleep Disturbances

Recent hospitalizations, operations, serious injuries, or illnesses lasting more than five (5) days:

_____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____

Any chronic disease? NO YES If YES, what? _____

PART IV: ACTIVITY/DIET RESTRICTIONS and MEDICATION INFO

Activity Restrictions? NO YES
If YES, list restrictions. _____

Diet Restrictions? NO YES
If YES, list restrictions. _____

Are you currently taking any medications? NO YES
If YES, list medication, reason, and possible side effects.

MEDICATION	REASON	POSSIBLE SIDE EFFECTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART V: IMMUNIZATION HISTORY

Immunization	Year Primary Series Completed OR Year of Last Booster
D.T.P.	_____
(Diphtheria, tetanus and pertussis (whooping cough))	_____
Td	_____
Adult Tetanus.....	_____
Diphtheria.....	_____
Hepatitis B.....	_____
Hib.....	_____
Measles.....	_____
Mumps.....	_____
Rubella (German measles).....	_____
Oral Polio	_____
Hbpv	_____
Tuberculin Test (most recent).....	Result: _____
Other (Specify):	_____
_____	_____
_____	_____
_____	_____