Girl Scouts Western Pennsylvania
800-248-3355 gswpa.org

ADULT HEALTH HISTORY

Date _____

Adult name_____

Address_____

Street City State Zip

Name of family physician _____Phone_____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ❑**Yes** ❑**No**

If so, indicate carrier or plan name _____Group #_____

HEALTH HISTORY

List any physical or behavioral conditions that may affect or limit full participation in Girl Scout activities:

_____

_____

_____

_____

Allergies (medication, food or other) _____

_____

RESTRICTIONS – The following restrictions apply to this individual

❑ Does not eat red meat ❑ Does not eat pork ❑ Does not eat eggs ❑ Does not eat dairy products

❑ Does not eat shellfish ❑ Does not eat poultry ❑ Other_____

Medications being taken (prescription and over-the-counter)

_____

_____

In case of an emergency please notify:

Emergency contact name_____

Relationship _____

Phone-Day ( )_____Evening ( ) _____

Emergency contact name_____

Relationship _____

Phone-Day ( )_____Evening ( ) _____

_____ _____

Participant's signature Date