girl scouts western pennsylvania

Adult Health History Form

Completed Date:_____
Troop/Group #: _____
Received By: _____
Received Date:_____

GENERAL INFORMATION

Adult's Name _____ Birth Date ____/____/____

Address _____
Street City State ZIP Code

Emergency Contact Information (First/Last name) _____

Relationship _____ Phone _____ Alt. Phone _____

INSURANCE INFORMATION

Carrier Name _____ ID Number _____

Member Services Phone _____ Group Number _____

Address _____
Street City State ZIP Code

Primary Care Physician _____ Primary Care Physician Phone _____

HEALTH CONDITIONS

Allergy	Reaction	Treatment	Date of Last Reaction?

Indicate in the space below any medical conditions (e.g., asthma, diabetes) that you have.

_____

_____

_____

Is there a specific dietary regiment to follow? (If Yes, please provide details below.) ❑ Yes ❑ No

_____

RECORD OF IMMUNIZATION

Date of last Tetanus vaccine ____/____/____

Select **one** of the following:

☐ I attest that all of my immunizations are up to date.

☐ I attest that I have not received immunizations. Note: Please contact CustomerCare@gswpa.org to obtain and complete an immunization waiver. The waiver is required for participation.

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MEDICATIONS

A qualified Health Care Professional (RN, LPN, DMD, or MD) or a PA Medication Administration certified approved volunteer may administer medications to participants. Arrangements between participants and GSWPA Approved Volunteers for all medications dispensed must include:

1. Prescription and over-the-counter medications must be provided in their original container.
2. Prescription medications must contain the physician prescribed orders, including instructions.
3. Both prescription and over-the-counter medications **must be given to the Approved Volunteer or First Aider/Health Care Professional.**
4. Some Life threatening conditions will require medications to be carried and secured by the participant, girl or adult, and are approved for carrying in first aid kits. These include: Epi-pens needed for insect stings or serious food allergies, asthma inhalers, and items needed for diabetic and seizure emergencies.

Prescription Medication:

In the space below, please list any prescription medication that you are required to take, including any self-administered emergency medication such as an Epinephrine injector or rescue inhaler.

Medication	Purpose	Self-Administer?
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

Over-the-Counter Medication:

In the list below, please select any over-the-counter medication that you are **NOT** permitted to take.

❑ Ibuprofen	❑ Calamine Lotion	❑ Liquid Tears	❑ Anti-fungal Cream
❑ Aloe Vera	❑ Cough Drops	❑ Menstrual Cramp Relief	❑ Antacid
❑ Bacitracin (i.e. Neosporin)	❑ Dramamine	❑ Expectorant	❑ Acetaminophen
❑ Antihistamine	❑ Antidiarrheal	❑ Decongestant	❑ Other _____

SIGNATURE

Please select the checkbox and sign and date this form:

☐ **Permission to Provide Necessary Treatment or Emergency Care**: I hereby give my permission to medical personnel selected by Girl Scouts Western Pennsylvania to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. In the event that my emergency contact cannot be reached, I hereby give my permission to the physician selected by Girl Scouts Western Pennsylvania to secure and administer treatment, including hospitalization for myself. This health history form is complete to the best of my knowledge, and I am permitted to engage in all program activities, except as noted. This completed form may be photocopied.

☐ **Permission to Self-Administer Medication**: I confirm that I have the knowledge to self-administer the indicated emergency medication as medically necessary at Girl Scout activities. The troop leader/first aider will be notified if I have used my medication.

_____ / /

Signature Date