girl scouts of southern alabama

Adult Health Form

Contact Information

Name _____ D.O.B. _____

Address _____ City/State/Zip _____

Telephone: Home # _____ Work # _____ Cell # _____

Emergency Contact _____ Relationship _____

Telephone: Home # _____ Work # _____ Cell # _____

Medical Information

Physician _____ Phone # _____

Medical Insurance _____ Subscriber _____ Policy/Group # _____

General Information:	yes	no
Frequent headaches	☐	☐
Corrective eye wear	☐	☐
Diabetes	☐	☐
Sleepwalking	☐	☐
Nosebleeds	☐	☐
Motion Sickness	☐	☐
Convulsions	☐	☐
Kidney	☐	☐
Heart	☐	☐
Fainting	☐	☐
Epilepsy	☐	☐

Allergies:	yes	no
Hay Fever	☐	☐
Poison Oak, etc.	☐	☐
Insect Stings	☐	☐
Asthma	☐	☐
Animals	☐	☐
Food	☐	☐
Drugs	☐	☐
Other	☐	☐

Special Needs:	yes	no
Disability	☐	☐
Hearing Impairment	☐	☐
Visual Impairment	☐	☐
Physical Impairment	☐	☐
Special Dietary Needs	☐	☐
Other Special Needs	☐	☐

If you checked yes to any of the boxes, please explain: _____

_____

_____

List any restrictions in activities (attach additional sheet if needed) _____

_____

List any medication you are currently taking, including over-the-counter medications (attach additional sheet if needed)

_____

This health history is complete and accurate. I certify that I am able to participate in this event/activity.

SIGNATURE of Adult _____ Date _____

Please complete second page.

Adult Health Form Continued

HEALTH INFORMATION PRIVACY STATEMENT

The Adult Health Form is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose responsibilities include 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 (first aider) of the specific event; during travel as part of a group to the event, this form will be located in the vehicle in which the individual is riding. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care.

The health form will be retained by the sponsoring council until it is destroyed, unless it is given to emergency medical personnel in the event of the individual's need for medical treatment other than by the event's first aider. Access to the information will be limited, but copies may be requested from the event sponsor or by the participant or her/his legal representative.
I have read the above procedures for handling the health form information, and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

SIGNATURE of Adult _____ Date _____

Medical Authorization

TO WHOM IT MAY CONCERN:

I, _____, do hereby consent to any surgical or medical treatment or procedures which may be suggested, recommended, prescribed, or directed by a duly licensed physician in their competent medical judgment as reasonably necessary and where any delay in treatment could reasonably be expected to jeopardize my life or health or could reasonably result in disfigurement or impairment to faculties or if the delay would cause undue psychological or emotional distress.

It is understood that this authorization is given in advance of any specific need for its use by a physician who in the exercise of his/her best medical judgment may deem it advisable to proceed in treating. It is understood that every effort shall be made to obtain consent prior to treatment, but the undersigned specifically directs that treatment not be withheld if the undersigned cannot give consent.

List any restrictions _____

This consent shall remain effective from _____ to _____.
(MM/DD/YY) (MM/DD/YY)

Signature _____ Date _____