

This form is required for all trips/events that occur away from the meeting place. This completed form, along with other necessary papers, must accompany adult chaperone during all events/trips/activities. Also, this necessary paperwork must be in the vehicles transporting the adults to whom they refer.

Name: _____ Date of Birth: _____ Sex: F M
 Last First Initial

Email Address: _____ Spouse: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Emergency Contact: _____ Phone: (____) _____

Family Physician: _____ Phone: (____) _____

Family Medical/Hospital Insurance Carrier: _____ Policy/Group #: _____

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|---|---|
| <p>Health History (check those that apply)</p> <p><input type="checkbox"/> Convulsions/Seizures <input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Sinusitis <input type="checkbox"/> Musculoskeletal Disorders</p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Lyme Disease <input type="checkbox"/> Bleeding/Clotting Disorders</p> <p><input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Other: _____</p> <p>Date of last tetanus shot: _____</p> <p>Diseases (check those that apply)</p> <p><input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles</p> <p><input type="checkbox"/> Mumps <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other (specify) _____</p> | <p>Allergies (check those that apply and specify the nature of the allergic reaction):</p> <p><input type="checkbox"/> Animals _____ <input type="checkbox"/> Pollen _____</p> <p><input type="checkbox"/> Plants _____ <input type="checkbox"/> Hay Fever _____</p> <p><input type="checkbox"/> Medicines/Drugs _____</p> <p><input type="checkbox"/> Food _____ <input type="checkbox"/> Insect stings _____</p> <p>Do you carry an Epi-pen? _____</p> <p>If yes, can you self-administer? _____</p> <p><input type="checkbox"/> Other (please explain) _____</p> |
|---|---|

Date of last health examination: _____ Complicating medical problems noted in last health examination _____

Check those that apply and describe:

Current care by a physician or psychologist _____

Serious injury or operation _____ An illness lasting more than five (5) days _____

Prescribed medication _____ Regularly taken over the counter medication _____

Recent exposure to a contagious disease _____

Restrictions concerning physical activity _____

Other Health Conditions (check those that apply).

Motion sickness Special dietary regimen Hearing impairment Sleep disorders

Emotional disturbances Fainting Nosebleeds Glasses/contact lenses

Fears Other: _____

Please explain any items checked above. Indicate any information useful to the adult in charge in relation to these health conditions: _____

Please indicate any activities to be encouraged or restricted. _____

The **Adult Health History Form** is for health care concerns at the specified event 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 form will be retained by the sponsoring council or GSUSA 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 form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Signature: _____ Date: _____