

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 _____ 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 # _____

Health History (check those that apply):

Convulsions/Seizures	Hypertension	Allergies (check those that apply and specify the nature of the allergic reaction):	
Sinusitis	Musculoskeletal Disorders	Animals _____	Pollen _____
Asthma	Diabetes	Plants _____	Hay Fever _____
Lyme Disease	Bleeding/Clotting Disorders	Medicines/Drugs _____	
Heart defect/disease	Other: _____	Food _____	Insect stings _____
Date of last tetanus shot: _____		Do you carry an Epi-pen? No	
Diseases (check those that apply)		If yes, can you self-administer? _____	
Chicken Pox	Measles	German Measles	
Mumps	Tuberculosis	Other (specify) _____	Other (please explain) _____

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: _____