

Print Form

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):

<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Hypertension	Allergies (check those that apply and specify the nature of the allergic reaction):
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Musculoskeletal Disorders	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Animals _____
<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Plants _____
<input type="checkbox"/> Heart defect/disease	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Medicines/Drugs _____
Date of last tetanus shot: _____		<input type="checkbox"/> Food _____
Diseases (check those that apply)		<input type="checkbox"/> Insect stings _____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> German Measles
<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other (specify) _____

Do you carry an Epi-pen? No Yes
 If yes, can you self-administer? _____
 Other (please explain) _____

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

Check those that apply and describe:

<input type="checkbox"/> Current care by a physician or psychologist _____	<input type="checkbox"/> An illness lasting more than five (5) days _____
<input type="checkbox"/> Serious injury or operation _____	<input type="checkbox"/> Regularly taken over the counter medication _____
<input type="checkbox"/> Prescribed medication _____	

Recent exposure to a contagious disease _____

Restrictions concerning physical activity _____

Other Health Conditions (check those that apply):

<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Special dietary regimen	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Sleep disorders
<input type="checkbox"/> Emotional disturbances	<input type="checkbox"/> Fainting	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Glasses/contact lenses
<input type="checkbox"/> Fears	<input type="checkbox"/> 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: _____