



ADULT HEALTH HISTORY RECORD FOR COUNCIL PROGRAMS

To be completed, signed, and returned to Council office no later than 1 week prior to activity.

Email to: customercare@gshawaii.org

or mail to: GSH, ATTN: Programs, 410 Atkinson Dr, S2E1 Box 3, Honolulu HI 96814

I do not wish to disclose personal medical information and choose not to complete this form. By making this choice, I understand that if I am in need medical assistance, the information requested of me by completing this form will not be provided to the health care giver and thus may result in less than optimal treatment. My acknowledgment below indicates that I read and fully understand the above.

Acknowledgment of Non-Consenting Adult	Date

Adult Participant Information

Name			
Full Address City/ST/Zip			
Date of Birth (mm/dd/yyyy)		Age	
Main Phone		Alternate Phone	
Email			
Troop Number/Name		Service Unit # Name	
Date of Event		Event Name	
Volunteer position/role if applicable			
Are you a currently registered Girl Scout Member?	Yes	No	Contact me to join!

Emergency Contacts/Physician/Insurance Info

In the event of an emergency please contact the following:

Primary Contact Name		Relationship	
Main Phone		Alternate Phone	
Secondary Contact Name		Relationship	
Main Phone		Alternate Phone	
Yes No - I have medical insurance coverage.			
Primary Physician Name		Main Office Number	
Pager Number		Alternate Phone	
Preferred Hospital		Hospital Office Number	
Medical Insurance Co		Policy #	
Insurance Co. Phone		If you are not a Military Dependent proceed to Part III	
If you are a Military Dependent provide the following information:			
Sponsor's Name		Sponsor's SSN last 4 #s	
Duty Station		Duty Phone	

Health Information

Allergies Check all that apply and provide the specific nature and treatment of the allergy

<input type="checkbox"/> No known allergies	<input type="checkbox"/> Animals
<input type="checkbox"/> Food	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Insects/Stings	<input type="checkbox"/> Medications/Drugs
<input type="checkbox"/> Plants	<input type="checkbox"/> Pollen
<input type="checkbox"/> Other a:	<input type="checkbox"/> Other b:

Name			
Date of Event		Event Name	

Health Information (continued)

Medications Please list all daily and as needed medications that you will be bringing on the trip. Include amounts taken, number of daily doses and routine administration times.

Name of Medication	Dosage	Time(s) Administered	Comments

Other Health Considerations Check any restrictions that apply and describe (leave blank if none apply)

Physical activities /description:
Medical/Emotional/Spiritual /description:
I will provide this special equipment for my use:
I have the following limitations/restrictions:

Immunizations (Indicate "as child" if you do not have a record of dates/leave blank if none apply)

I have not received any immunizations					
Immunization	Primary Series	Last Booster	Immunization	Most Recent	Last Booster
COVID 19			Tuberculin Test		Result
All participants for Council events must submit this waiver			Tetanus		
Yes	No-I may receive a COVID test if necessary		Yes	No-I may receive a Tetanus shot if necessary	

Exposure acknowledgment In the last 14-days have you or anyone in your household:

Yes	No- Recently tested positive for Covid-19? Or been in close contact with anyone that has tested positive?
Yes	No -Is anyone in your household or close contact awaiting Covid-19 Testing results?
Yes	No-Have you or anyone in your household exhibit Covid-19 (flu-like) symptoms?
Yes	No-Have you or anyone in your household traveled outside of the state of Hawaii?
Yes	No-Have you been sent home from or missed school / work due to illness?

Authorization of Consent for Emergency Treatment

I hereby authorize the designated nurse and or first aid certified person for this trip/activity or in their absence or disability, any adult accompanying or assisting this trip/activity to seek emergency medical treatment, if necessary from a licensed physician.

Acknowledgement of Consenting Adult	Date

Media Release

I acknowledge that I am eighteen (18) years of age or older. I hereby grant to Girl Scouts of the USA ("GSUSA"), and others working for GSUSA or on its behalf, and each of its respective licensees, successors and assigns (each a "Release"), the irrevocable, royalty-free, perpetual, unlimited right and permission to use, distribute, publish, exhibit, digitize, broadcast, display, modify, create derivative works of, reproduce or otherwise exploit my name, picture, likeness and voice (including any video footage of the same), testimonials (written by me or attributed to me), interviews (written by me or attributed to me) (collectively, "Media"), or to refrain from so doing, anywhere in the world, by any persons or entities deemed appropriate by GSUSA, for any purpose including, without limitation, any use for educational, advertising, non-commercial or commercial purposes in any manner or media whatsoever (whether known or hereafter devised) including, without limitation, on the internet, in print campaigns, in-store and via television.

I hereby release and hold harmless from any claim for injury, compensation or negligence resulting or arising from any activities authorized by this Release and any use of the Media by GSUSA.

Yes No - I release any obligation on GSUSA and/or GSH and allow any use of the media or rights granted.

Acknowledgement of Consenting Adult	Date

All acknowledgments state acceptance and accuracy at the date of this document is submitted.