girl scouts of hawai`i

ADULT HEALTH HISTORY RECORD

Adult Health History (page 1 of 3) Name

Date Submitted

All adults participating in Extended Overnight Trips of four (4) nights or more (on-island or off-island) are required to complete and submit an Adult Health History Record for each event.

Information included on this form is confidential and should only be shared with persons who have a need to know in order to protect the health and safety of the participant and other participants.

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 this statement.

Acknowledgement of Non-Consenting Adult	Date

PART I: Adult Participant Information			
Section A: Participating Adult Information			
Name			
Full Address City/ST/Zip			
Date of Birth (mm/dd/yyyy)		Age	
Main Phone		Alternate Phone	
Email			
Section B: Troop/Service Unit Information			
Troop Number/Name		Service Unit #/ Name	
Volunteer Position if appicable			
Are you a currently registered Girl Scout Member? ◯ Yes ◯ No ◯ Contact me to join!			

PART II : Emergency Contacts/Physician/Insurance Info			
Section A: Emergency Contact(s) - 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	
Section B: Primary Physician/Insurance			
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	

PART III: Health History

Section A: Chronic or Recurring Illnesses / Check all that apply

	Angina		Arthritis		Asthma
	Bleeding/clotting disorders		Diabetes		Heart defect/disease
	Hypertension		Musculoskeletal disorders		Seizures
	Other 1:		Other 2:		Other 3:

Additional Notes:

Section B: Allergies / Check all that apply and provide the specific nature and treatment of the allergy

	Animals	
	Food	
	Hay Fever	
	Insect Stings / specify & explain	
	Medication/Drugs	
	Plants	
	Pollen	
	Other	

Additional Notes

Section C: Diseases / Check all that you have had

	Chicken Pox		German Measles		Kidney
	Measles		Mumps		Heart defect/disease
	Rheumatic Fever		Tuberculosis		Other:

Additional Notes

Section D: Other Health Conditions / Please check all that apply and provide specifics/explanations below:

	Eyesight -Wear Contact Lenses		Eyesight -Glasses		Fainting
	Hearing Impairment		Motion Sickness		Nosebleeds
	Sleep Disturbances		Special Dietary Regime		Other

Section E: Other Health Conditions / Check any retrictions that apply and describe (leave blank if none apply)

	Physical activities	
	Medical/Emotional/Spiritual	

Section F: 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	Primary Series	Last Booster
COVID 19			Oral Polio		
DTP			Rubella		
Diphtheria			Td		
Measles			Tuberculin Test	most recent	result
Mumps			Other:		
Pertussis			Other:		

PART IV: Last Health Examination and Restictions

Date of last exam:		Complications noted? ◯ Yes ◯ No	
Explain any complications			

Check any treatment or retrictions that apply and describe (leave blank if none apply)

	Currently under care of a physician or psychologist
Explain treatment	
	Had an illness lasting more than five days
Provide Details	
	Had surgical operation or fracture?
Provide Details	
	A serious injury requiring medical attention?
Provide Details	
	Received treatment at a hospital?
Provide Details	

PART V: 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	Times Administered/Day	Time(s) Taken	Comment
I may receive a Tetanus shot, if necessary ◯ Yes ◯ No			Last Tetanus shot date	
I may receive a COVID-19 test, if necessary ◯ Yes ◯ No				

PART VI: Authorization of Consent for Emergency Treatment

By entering my name below and submitting this document, I 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.

Acknowledgment Consenting Adult	Date