girl scouts of southern nevada

Health History Form

All information will be kept confidential.

Please specify below:

☐ Girl Health History ☐ Adult Health History

Name: ____
Last First M.I.

Address:________________________________City/St/Zip______________________

Gender______________ Date of Birth:________/______/______ Phone: (_______)______________________

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Emergency Contact Name:	Relationship:
Address:	Phone:
Physician's Name:	Physician's Phone:
Insurance Provider:	Policy/Group #:
Insured's Name:	Relationship to Insured:

Medical History

Has the person listed been hospitalized in the last five years? ☐Yes ☐ No
Is the person listed taking any medications? ☐Yes ☐ No
If yes, please explain: ____
Is the person listed up to date with immunizations? ☐ Yes ☐ No
If no, is the person exempt for ☐ religious or ☐ medical reasons? (Please check one)

Please indicate if if the person listed has had any of the following: ✓							
	ADHD		Arthritis		Bedwetting		Bleeding/Clotting Disorders
	Blood Pressure Disorders		Chicken Pox		Diabetes		Disease of Ears/Frequent Ear Infections
	Eyesight Impairment		German Measles		Hayfever/Asthma		Hearing Impairment
	Heart Disease		Hernia		Hypoglycemia		Intestinal Disorders
	Kidney Disease		Measles		Mental/Emotional Disorders		Mumps
	Nervous System Disorders		Rheumatic Fever		Seizures		Severe Menstrual Pain
	Sinusitis		Speech Impairment		Tuberculosis		Visual Impairment
Other Serious Allergies:							
Special Needs:							
Dietary Needs:							

The above health history and special needs are correct to the best of my knowledge and the person listed above is able to engage in all activities, except as noted. All information will be kept confidential.

Person/Caregiver Signature:________________________________**Date:** ____________________

PERMISSION FOR EMERGENCY TREATMENT FOR GIRL/ADULT LISTED ABOVE	
In the event (Girl or Adult Listed Above) ____________________becomes ill or sustain an injury while in the care of or under the supervision of Girl Scouts of Southern Nevada or any of its officers or leaders, I authorize First Aid to be administered. If it should become necessary to seek professional medical treatment, I give my permission for a licensed medical professional to administer any medical and/or surgical treatment she/he deems necessary, including hospitalization. I understand that every effort will be made to contact the party listed under "Emergency Contact." I accept full financial responsibility for all expenses incurred that are not covered by Girl Scout Activity Insurance.	
Signature:	Date:

DO NOT SIGN BELOW IF YOU HAVE SIGNED THE ABOVE EMERGENCY TREATMENT PERMISSION SECTION	
I **do not** desire the authorization and understand that in doing so I release and relieve for all liability whatsoever Girl Scouts of Southern Nevada, its officers or leaders.	
Signature:	Date: