



ADULT HEALTH HISTORY

Date _____

Adult name _____

Address _____

Street

City

State

Zip

Name of family physician _____ Phone _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

HEALTH HISTORY

List any physical or behavioral conditions that may affect or limit full participation in Girl Scout activities:

Allergies (medication, food or other) _____

RESTRICTIONS – The following restrictions apply to this individual

Does not eat red meat Does not eat pork Does not eat eggs Does not eat dairy products

Does not eat seafood Does not eat poultry Other _____

Medications being taken (prescription and over-the-counter)

In case of an emergency please notify:

Emergency contact name _____

Relationship _____

Phone-Day () _____ Evening () _____

Emergency contact name _____

Relationship _____

Phone-Day () _____ Evening () _____

Participant's signature _____

Date _____