

<b>Health History Record</b>							Adult <input type="checkbox"/>	Girl <input type="checkbox"/>
NAME OF MEMBER		DATE OF BIRTH		SEX	AGE	TROOP/GROUP NO.	PARENT/GUARDIAN NAME(S)	
ADDRESS						PHONE: (AREA CODE) DAY		(AREA CODE) EVENING
CITY		STATE	ZIP	PHONE: (AREA CODE) DAY		(AREA CODE) EVENING	FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER	
IN EMERGENCY NOTIFY: NAME		RELATIONSHIP		PHONE: (AREA CODE) DAY		(AREA CODE) EVENING		POLICY OR GROUP NO.
IN EMERGENCY NOTIFY: NAME		RELATIONSHIP		PHONE: (AREA CODE) DAY		(AREA CODE) EVENING		

CHECK THOSE THAT APPLY

**ALLERGIES:**

ANIMALS \_\_\_\_\_

FOOD \_\_\_\_\_

PEANUT \_\_\_\_\_

HAY FEVER \_\_\_\_\_

INSECT STINGS \_\_\_\_\_

MEDICINE/DRUGS \_\_\_\_\_

PLANTS \_\_\_\_\_

POLLEN \_\_\_\_\_

OTHER (SPECIFY) \_\_\_\_\_

**CHRONIC OR RECURRING ILLNESS:**

HEART DEFECT /DISEASE \_\_\_\_\_

SEIZURES \_\_\_\_\_

BLEEDING/CLOTTING \_\_\_\_\_

ASTHMA \_\_\_\_\_

DIABETES \_\_\_\_\_

OTHER (SPECIFY) \_\_\_\_\_

HAD ANY RESTRICTIONS CONCERNING PHYSICAL ACTIVITIES? \_\_\_\_\_

PLEASE DESCRIBE ANY CONDITIONS: \_\_\_\_\_

This health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me. In case of illness or injury, I/we give permission for her to receive first aid, and to receive emergency treatment from a licensed physician, emergency medical services, or other health care professional. It is understood that all reasonable efforts will be made to contact the parent or guardian.

SIGNATURE OF PARENT(S)/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.

SIGNATURE OF ADULT \_\_\_\_\_ DATE \_\_\_\_\_

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SIGNATURE OF ADULT \_\_\_\_\_ DATE \_\_\_\_\_