

ADULT HEALTH EXAMINATION RECORD

This part to be filled in by adult and reviewed with physician at the time of examination

| | | | | | |
|--------------------------------------------------------------|---------------------|---------------------|---------------------|--------------|--------------|
| Name (Last, First, Initial) | | | | Sex | Birth |
| | | | | | |
| Address | City or Town | State | Zip | Phone | |
| | | | | () | |
| In Emergency Notify | Address | Relationship | | Phone | |
| | | | | () | |
| Insurance Information, please complete the following: | | | | | |
| Carrier | ID Number | | Group Number | | |
| | | | | | |
| Member Services Phone Number | | Address | | | |
| | | | | | |

Health History: (Check if you have had any of the following)

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Eyesight Impairment <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Disorders of Nervous System <input type="checkbox"/> Sinusitis <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Disease of Kidneys <input type="checkbox"/> Heart Disease <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Abnormal Blood Pressure <input type="checkbox"/> Mental or Emotional Disorders <input type="checkbox"/> Severe Menstrual Pain | <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hernia <input type="checkbox"/> Asthma or Hay Fever <input type="checkbox"/> Other serious allergies | <input type="checkbox"/> Disease of Ears <input type="checkbox"/> Intestinal Disorders <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> German Measles <input type="checkbox"/> Other |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Have you been hospitalized in the last five years? Yes No. Are you taking any medication? Explain.

If you have checked or answered yes to any of the above, give nature, dates, period of any disability and results:

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN BELOW— INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

I certify that to the best of my knowledge this health history is complete and accurate. I am in good health and able to participate in this event/assignment.

Signature of Applicant: _____

Date: _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Adult Health Examination Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

SIGNATURE: _____ DATE: _____
 (Participant)

