girl scouts of greater chicago and northwest indiana

**NOTE:** This form must be completed and signed by adult members. All Health History Forms will be held in limited access by the trustee (leader/facilitator/staff) of the specific Girl Scout program. The absolute minimal necessary information may be shared with program staff/volunteers in order to provide adequate health care. The Health History Form will be retained by the Girl Scout program trustee until it is destroyed.

# Adult Health History Form

**Name**_____

**Address**_____

**City**_____ **State**_____ **Zip Code**_____

**Preferred Phone**_____ **Birth Date**_____

**Name of Family Physician**_____

**Physician's Phone**_____ **Date of Last Exam**_____

**Name of Insurance Company**_____

**Policy or Group No.**_____

**Age Group** ☐ 18-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ Over 61

**Major Health Conditions (check all that apply)**

☐ Bleeding/clotting problems ☐ Hypertension ☐ Asthma ☐ Seizures
☐ Heart problems ☐ Hypoglycemia ☐ Bone/Joint problems ☐ Diabetes
☐ Sickle Cell trait or disease ☐ Other (specify) _____

**Allergies (check all that apply and specify nature of allergic reaction)**

☐ Animals _____ ☐ Hay fever_____ ☐ Medicines_____
☐ Pollen_____ ☐ Food_____ ☐ Insect stings_____
☐ Plants_____ ☐ Other (specify)_____

**Other Health Conditions (check all that apply)**

☐ Menstrual cramps ☐ Fainting ☐ Hearing problems ☐ Nosebleeds
☐ Wears glasses/contact lenses ☐ Medicines taken_____
☐ Special dietary needs_____ ☐ Other (specify)_____

Please explain any items that are checked. To the best of your knowledge, do you have any physical or emotional condition that might prevent you from participating in Girl Scout activities? ☐ No ☐ Yes (explain)

_____

_____

_____

**IMMUNIZATION HISTORY**

**Please check if immunizations/boosters are up-to-date**

☐ DPT or DT&P (Diphtheria, Pertussis [whooping cough], and Tetanus)
☐ TD or DT (Diphtheria and Tetanus)
☐ Measles
☐ Mumps
☐ Rubella (German Measles)
☐ Combined MMR (Measles, Mumps, and Rubella)
☐ Hib (Haemophilus influenzae type b)
☐ Polio
☐ Hepatitis B (HB)
☐ Tuberculin Test: Result _____
☐ Other (e.g., Varicella – chicken pox)_____

_____

## Emergency Contact

Emergency Contact Name:_____

Relationship to Adult:_____

Contact Primary Phone: _____

Contact Secondary Phone: _____

Please turn form over.

Girl Scouts of Greater Chicago and Northwest Indiana

# Adult Health History Form

**Please update and sign this form annually. Initial and date any changes.**

I do hereby authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my life, cause disfigurement, physical impairment, or undue discomfort, if delayed.

Providing false or incomplete information is a serious matter that may result in liability for damages and/or fraud.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

## Consent for Release of Personal and Health Information

**New compliance form for Health Insurance Portability Accountability Act (HIPAA)**

I authorize the use or disclosure of personal and health (includes medical, dental, and pharmacy) information by Girl Scouts of Greater Chicago and Northwest Indiana, as described below:

> Any and all personal and health information Girl Scouts of Greater Chicago and Northwest Indiana maintains (including mental health, HIV, and/or substance abuse records – cross out any item you do not authorize to be released). *Note: This consent form allows personal and health information to be shared via a telephone call with the person being authorized.*

This information may be disclosed to, and used by, the following individuals or organizations, including any medical personnel listed on health history portion, or any medical personnel attending to me during a medical emergency.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Girl Scouts of Greater Chicago and Northwest Indiana.

I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will apply while I am a member of Girl Scouts of Greater Chicago and Northwest Indiana.

I understand that I do not have to sign this authorization and that Girl Scouts of Greater Chicago and Northwest Indiana may not condition treatment on whether I sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of member, legal representative, or parent/guardian, if under 18 years of age:

Name:_____ Date:_____

If signed by legal representative or guardian, relationship to member:

Relationship:_____

If signed by legal representative, please provide representative documentation as required by state law, i.e., Power of Attorney, Health Care Surrogate, Living Will, or guardianship papers.