Girl Scouts of the Jersey Shore
ADULT HEALTH HISTORY

_____ ( ) _____
Name (Last, First, Initial) (Area Code) Phone #

_____
Address Town State Zip

_____ ( ) _____
In Emergency Notify Address (Area Code) Phone #

_____
Family Medical/Hospital Insurance ID#

Physician Name: _____

Part I: Illness & Injuries

_____ *Asthma* _____*Ear Infection* _____*Kidney Disease* _____*Convulsions*

_____*Diabetes* _____*Epilepsy* _____*Heart Disease* _____*Other:*

Last Health Examination: Date _____ **Last Tetanus Shot: Date** _____

Were any complicating medical problems noted at that time?_____ Specify:_____

_____

Since last health examination, have you had:

	Yes	No
A serious injury requiring medical attention?	( )	( )
An illness lasting longer than one week?	( )	( )
A surgical operation or fracture?	( )	( )
Medication prescribed by a physician to be taken on a regular basis?	( )	( )
Treatment in a hospital as an impatient (or) in the emergency room?	( )	( )

Please explain any "YES" answers to above questions – include dates.

_____

_____

Part II: Allergies (*check those that apply and specify exact source)*

_____ Animals _____ _____ Food _____

_____ Hay Fever _____ _____ Insect Stings _____

_____ Medicine/Drugs _____ _____ Plants _____

_____ Pollen _____ _____ Other _____

Part III: Other Health Conditions – Please specify. Indicate any information that would be useful to the First Aider in charge regarding your conditions.

_____

_____

Signature: _____ Date:_____