Girl Scouts Western Pennsylvania
800-248-3355 ♣ gswpa.org

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:

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Allergies (medication, food or other) ____
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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 shellfish ❑ Does not eat poultry ❑ Does not eat peanuts
❑ Allergy to latex ❑ Allergy to stinging insects ❑ Other_____________________________

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

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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