Last Name: **First Name:**

Name *last* ____________________________ *first* ______________________________

Age _________________________________ Birthdate _________________________

Home Phone (   ) __________________ Work Phone (   ) _______________

Cell Phone (   ) ___________________ e-mail ___________________________

Home Address ____

City _____________________________ State ________ Zip Code _______________

2 Emergency Contacts:

Name *last* ____________________________ *first* _____________________________

Day phone (   ) ____________________ Night phone (   ) ________________

Name *last* ____________________________ *first* _____________________________

Day phone (   ) ____________________ Night phone (   ) ________________

Insurance:

Insurance Carrier or Plan Name ____

Group # ____

Health History (please explain "yes" answers below.)

Has / does the participant:	Yes	No		Yes	No
1. Had an recent injury, illness Infectious disease?	☐	☐	13. Have been diagnosed with heart disease?	☐	☐
2. Have a chronic or recurring Illness or condition?	☐	☐	14. Have diabetes?	☐	☐
			15. Have asthma?	☐	☐
3. Ever been hospitalized?	☐	☐	16. Had mononucleosis in the past 12 months?	☐	☐
4. Ever had surgery?	☐	☐			
5. Have frequent headaches?	☐	☐	17. Had problems with diarrhea or constipation?	☐	☐
6. Ever had a head injury?	☐	☐			
7. Ever been unconscious?	☐	☐	18. Vision Problems?	☐	☐
8. Have frequent ear infections?	☐	☐	19. Hearing Problems?	☐	☐
9. Ever had seizures?	☐	☐	20. Eating disorder?	☐	☐
10. Have high blood pressure?	☐	☐	21. Emotional difficulties?	☐	☐
11. History of nosebleeds?	☐	☐	22. Any other significant medical issue?	☐	☐
12. Ever fainted?	☐	☐			

Please explain any "yes" answers, noting the number of the questions.

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Please attach additional pages if needed for further explanation.

Medication Allergies (list)	Describe reaction & management of reaction
________________________	____________________________________
________________________	____________________________________
________________________	____________________________________

Food Allergies (list)	Describe reaction & management of reaction
________________________	____________________________________
________________________	____________________________________
________________________	____________________________________

Other Allergies (list)	Describe reaction & management of reaction
________________________	____________________________________
________________________	____________________________________
________________________	____________________________________

Medications:

This person takes medications as follows: (include prescription and over-the-counter)

Med #1 ____________________ Dosage _______ Times taken each day _________

Reason for taking ____

Med #2 ____________________ Dosage _______ Times taken each day _________

Reason for taking ____

Med #3 ____________________ Dosage _______ Times taken each day _________

Reason for taking ____

Other Special Considerations / Dietary Concerns:

____

____

____

Authorization & Permission to Provide Necessary Treatment or Emergency Care:

The undersigned do hereby authorize the officers, leaders or agents of Girl Scouts of Greater Los Angeles, to consent to any x-ray examination, anesthetic, medical or surgical treatment and hospital care to be rendered under the general or special supervision and upon the advice of a physician or surgeon licensed under the provisions of the Medical Practice Act, or to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care rendered by a dentist licensed under the provisions of the Dental Practice Act. It is further understood that permission is hereby granted to the officers, leaders or agents of Girl Scouts of Greater Los Angeles to obtain and administer such medical aid or assistance as might, in their judgment, be required for your immediate care. In the event of such help, Girl Scouts of Greater Los Angeles, its officers, leaders and agents will not be held liable for any first aid treatment or hospital care rendered drugs, medicine or surgical procedures performed pursuant to this consent. This consent supersedes all prior authorization.

Signature ____ Date ___________