Girl Scouts®

ADULT HEALTH HISTORY

council emergency # (602) 531-5935

Troop # _____

Adult _____

Address _____

Phone _____ Alt Phone _____

Email _____

EMERGENCY CONTACT

Name _____

Phone _____ Alt Phone _____

Address _____

City _____ State/Zip _____

I do hereby authorize medical attention from a qualified and licensed medical doctor/healthcare provider in the event of a medical emergency, and the transportation to a medical facility if required.

_____ _____

Signature **Date**

Please note any health condition or concern that should be considered during activities.

_____ Asthma
_____ Diabetes
_____ Convulsions
_____ Heart Disease
_____ Glasses/Contact Lenses
_____ Kidney/Bladder Problems

Other: _____

Other: _____

Allergies (Please Specify)

- ☐ Animals _____
- ☐ Medicine/Drugs _____
- ☐ Foods _____
- ☐ Hay Fever _____
- ☐ Insects Stings _____
- ☐ Other _____

The following information is commonly requested by the emergency treatment facility:

Date of Birth ____ /____/____

Approximate Date of Last Tetanus Shot ____ /____

_____ _____

Name of Doctor/Healthcare Provider **Phone**

_____ _____

Name of Insurance Provider (if any) **Policy/Group #**

GIRL SCOUTS–ARIZONA CACTUS-PINE COUNCIL, INC.

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