girl scouts of western new york

GIRL SCOUTS OF WESTERN NEW YORK, INC.

ADULT HEALTH STATEMENT

PLEASE FILL OUT THIS FORM COMPLETELY

Last Name:	First Name:		MI:
Address:	City:	State:	Zip:
Phone (home):	Phone (cell):	Email:	

IN CASE OF EMERGENCY NOTIFY:	**IF CANNOT BE REACHED, NOTIFY:**
Name:	Name:
Phone Number (s):	Phone Number (s):
Address:	Address:
Relationship:	Relationship:

HEALTH INSURANCE	
Type of Insurance:	Insurance #:
Does your insurance require a pre-approval phone call? ☐ Yes ☐ No	
Doctor's Name:	Doctor's Phone Number:

CONFIDENTIAL HEALTH HISTORY			
			If yes, please explain your condition further:
Do you have any allergies?	☐ Yes	☐ No	
Do you have asthma?	☐ Yes	☐ No	
Do you have high blood pressure?	☐ Yes	☐ No	
Are you a diabetic?	☐ Yes	☐ No	If yes, do you take insulin?
Are you on a special diet?	☐ Yes	☐ No	
Date of most recent tetanus shot:	☐ Yes	☐ No	
Comments on any other health factors to which we should be alerted?			

MEDICATION:		
Are you on any medication?	☐ Yes	☐ No
State medication(s) and dosage(s):		

This health statement is complete and true to the best of my knowledge. I also understand that this information will be shared on a need-to-know basis with appropriate medical personnel. I hereby give permission for the adult in charge to secure the services of a licensed physician, if necessary and to give proper treatment for any injury or illness that is deemed necessary.

Signature: _____ Date:_____

(#350-AD-HLT)