

Last Name: _____	First Name: _____
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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?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have been diagnosed with heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring Illness or condition?	<input type="checkbox"/>	<input type="checkbox"/>	14. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	16. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	17. Had problems with diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	18. Vision Problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	19. Hearing Problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	20. Eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	21. Emotional difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	22. Any other significant medical issue?	<input type="checkbox"/>	<input type="checkbox"/>
11. History of nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Ever fainted?	<input type="checkbox"/>	<input type="checkbox"/>			

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

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 _____