

**Adult Health History for Fayette-Jessamine Girl Scout Day Camp**

Name(Last, First MI): \_\_\_\_\_

Date of birth: \_\_\_\_\_ Home Phone# \_\_\_\_\_

In case of emergency Name/relation: \_\_\_\_\_ Phone#: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

**Allergies AND Reaction to allergy:**

**Insects** \_\_\_\_\_

**Environmental (pollen, trees...)** \_\_\_\_\_

**Medications** \_\_\_\_\_

**Food** \_\_\_\_\_

**Other** \_\_\_\_\_

*All prescription medication needs to have the pharmacy label attached.*

**History of Illness or Health Concerns:**

**Asthma**                       **Heart Disease**                       **Syncope/Fainting**

**Anxiety/Behavior**                       **Kidney Disease**                       **Other**

**Ear Infections**                       **Urinary/Bladder**

**Diabetes**                       **Seizures**

Please describe (frequency, signs/symptoms): \_\_\_\_\_

\_\_\_\_\_

**\*\*Immunization record must be attached\*\***

**Date of last Tetanus Vaccine:** \_\_\_\_\_

**Current Medications (please include dose and frequency of use):**

***Any health information you would like camp staff to be aware of:***

**I understand that the information that is on this form will be used to keep myself safe and in the event of an accident will be used to seek medical treatment. I hereby give permission to the staff representative(s) at the Wilderness Road Girl Scout Council and/or the troop/group leader(s) and/or chaperone(s) to seek emergency medical treatment due to an accident or illness while participating in Girl Scout activities.**

**.In the event, I am unresponsive; I authorize the hospital and/or physician(s) to administer treatment to my self; and release of any records necessary for insurance purposes. I understand that I am responsible for any balance that is incurred from the hospital and/or physician.**

**Print Name \_\_\_\_\_**

**Signature \_\_\_\_\_**