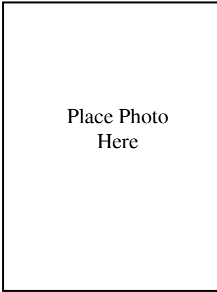
American Heritage Girls, Inc.
Health and Medical History Form

This form is valid for 12 months



Member Name: ____ Troop # __________________

Date of Birth: _____/_____/_____ Age: ________ Weight___________ Gender: ____________

Custodial parent/guardian: ____

Home address: ____

City: ____________________________________ State: ________ Zip Code:___________

Home phone: _________________________ Work/cell phone: ________________________________

If parent/guardian above cannot be reached in the event of an emergency, notify:

Name:____

Relationship:__________________________________ Phone #:_______________________

Name:____

Relationship:__________________________________ Phone #:______________________

Insurance Information

- ☐ Member does not have health care coverage at this time
- ☐ Member has health care coverage as listed below

Insurance Provider ____

Address ____ Phone # __________________

Policy Holder _____________________________________ Policy #______________________

Group # ____ Effective Date __________________

Primary Care Physician ____

Physician's address:____ Phone #: ________________

Dentist's name:____

Dentist's Address:____ Phone #:________________

Preferred Hospital:____

ALLERGIES:

Please list all known allergies including those to medications, food and environment. If none known, please write "none known". Attach additional page to this form if needed.

Allergy to:	Normal reaction and management of the reaction

GENERAL HEALTH INFORMATION:

(Please circle all items that apply, **past or present,** to your health history. Explain all "Yes" answers.)

Back Problems	YES	NO	High Blood Pressure	YES	NO
Chronic or recurring illness/condition	YES	NO	History of Asthma?	YES	NO
Contacts/glasses	YES	NO	History of ADD or ADHD	YES	NO
Convulsions/Seizures	YES	NO	History of bed-wetting?	YES	NO
Diabetes	YES	NO	History of Cancer/Leukemia?	YES	NO
Diagnosed with a heart murmur?	YES	NO	History of Sleepwalking?	YES	NO
Ear infections	YES	NO	Joint Problems (knees, ankles etc.)	YES	NO
Emotional disturbances	YES	NO	Kidney Disease	YES	NO
Ever had a head injury	YES	NO	Menstrual Cramps	YES	NO
Ever been hospitalized?	YES	NO	Migraine Headaches	YES	NO
Ever had surgery	YES	NO	Motion sickness	YES	NO
Fainting	YES	NO	Nose bleeding	YES	NO
Had mononucleosis in the past 12 months	YES	NO	Problems with diarrhea/constipation	YES	NO
Hearing impairment	YES	NO	Recent injury, illness or infectious		
Heart Disease	YES	NO	disease? (within last 6 months)	YES	NO
Hemophilia or other Bleeding Disorder	YES	NO	Skin problems (rash, itching etc.)	YES	NO

Explain any "YES" answers:

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IMMUNIZATIONS:

Year primary series completed   Year of last booster

DPT________________________ ___________________   Oral Polio____________________ ___________________

Measles_____________________ ___________________   Rubella______________________ ___________________

Mumps______________________ ___________________   Tetanus Shot__________________ ___________________

Tuberculin Test: Type:___________   Year last given:________ Result:_________

Medications

Please include all medications the participant is currently taking. If these medications need to be administered during an AHG event, the Request for Medication Administration form must be completed.

Medicine Name	Dose	Time	Reason taking/instructions

Date of last physical examination:___________________________

Over the Counter, As Needed Medications

The following are OTC medications that may be available at AHG functions on an as-needed basis. Please consult with your physician and indicate which medications the participant may receive.

OTC drug name (generic may be used.)	Indications	Permission	Comments
Benadryl	Allergies or Allergic Reaction	Yes No Yes No	
Acetaminophen Ibuprofen	Fever, Headache or Discomfort	Yes No Yes No Yes No	
Caladryl Hydrocortizone Cream	Insect Bites or Plant Reactions	Yes No Yes No	
Chloraseptic Throat Drops	Sore Throat	Yes No Yes No	
Pepto Bismol Tums	Upset Stomach	Yes No Yes No	
Peroxide Neosporin	Wounds (Cuts, abrasions, etc.)	Yes No Yes No	

I give permission for the medication indicated above to be given to my child (or self if an adult participant) if needed.

Signature of Parent/Guardian or Adult_______________________________________ Date _________________

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health needs pertinent to his/her participation in the American Heritage Girls program.

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I give permission for full participation in American Heritage Girls programs, subject to limitations noted herein.

This health history is correct and complete, as far as I know. I hereby give permission for AHG leadership to administer prescribed and noted over the counter medications.

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event that I cannot be reached, I hereby give my permission to the licensed health-care provider selected by the adult leader in charge to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if member is an adult), except as noted. I agree to the release of records necessary for treatment. Notes: ____

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Date _________Signature of parent/guardian or adult ____

I do NOT give my consent for medical treatment of my child (or for me, if member is an adult). In the event of illness or injury requiring treatment, I wish AHG leadership to take NO action beyond basic first-aid measures.

Date ________ Signature of parent/guardian or adult ____