



Girl Scouts of Northern California
Adult Health History

Please print clearly, with a black or blue ink pen. A signed health history form must accompany every registration.

Name _____ Birth Date _____

In case of emergency, please notify:

Name _____

Street Address _____

City _____ State _____ Zip _____

Day phone (____) _____ Eve. Phone (____) _____ Other Phone (____) _____

Name of Physician _____ Phone: _____

Medical Insurance Company and Plan Number _____

Medical History

Are you currently taking medications: Yes No

If yes, please describe: _____

Are you allergic to any medications? Yes No

If yes, please describe: _____

Do you have any allergies? Yes No

If yes, please describe and how to treat: _____

Please provide any additional information that may affect your participation at this event.

Authorization to consent to emergency medical treatment

In the event of an emergency, every effort will be made to contact the emergency contact. If no contact can be made, I hereby give authorization to Girl Scout of Santa Clara County to seek treatment for myself by a licensed physician pursuant to Section 6910 of the Civil Code of California. I know of no reason other than the information indicated on this form, I should not participate in prescribed activities except as noted.

Signature

Date _____