# AHG Member Health and Medical History Form

This form is valid for 12 months.
This form should be kept at the Troop level.

Place GirlMember Photo Here (if applicable)

**Member Information**

Member Name: _____

Troop #: _____ Date of Birth: _____/_____/_____ Age: _____

Weight: _____ Height: _____

Custodial parent/guardian (if applicable):_____

Home address: _____

City: _____ State: _____ Zip Code:_____

Home phone: _____ Work/cell phone: _____

Emergency Contacts:

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 are known, please write “none known.” Attach additional pages or documentation to this form if needed.

| **Allergy to:** | **Normal reaction and management of 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 | Kidney Disease | YES NO |
| Joint Problems (knees, ankles etc.) | YES NO | Menstrual Cramps | YES NO |
| Emotional disturbances | YES NO | Migraine Headaches | YES NO |
| Ever had a head injury | YES NO | Motion sickness | YES NO |
| Ever been hospitalized? | YES NO | Fainting | YES NO |
| Ever had surgery | YES NO | Nose bleeding | YES NO |
| Hearing impairment | YES NO | Recent injury, illness or infectious | YES NO |
| Problems with diarrhea/constipation | YES NO | Heart Disease | YES NO |
| Skin problems (rash, itching etc.) | YES NO | | |

Recent injury, illness or infectious disease? (within last 6 months) YES NO

Had mononucleosis in the past 12 months? YES NO

Hemophilia or other Bleeding Disorder? YES NO

**Explain any “YES” answers:**

_____

_____

_____

**Immunizations:** (Fill out the following portion of this form or attach a copy of the AHG Member's immunizations record. If said AHG Member does not have an immunizations record, please refer to the *Immunization Exemption Form.)*

| | Year primary series completed | Year of last booster |
|---|---|---|
| **DPT** | | |
| **Oral Polio** | | |
| **Measles** | | |
| **Rubella** | | |
| **Mumps** | | |
| **Tetanus Shot** | | |

Tuberculin Test: Type: _____ Year last given: _____ Result:

**Medications (For Girl Member use only.)**
Please include all medications the participant is currently taking. If these medications need to be administered to an AHG Girl Member during an AHG event, the Request for Administration of Medication form must be completed.

| Medicine Name | Dose | Time | Reason taking/instructions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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 their participation in the American Heritage Girls program.

_____

_____

_____

_____

_____

I give permission for full participation in American Heritage Girls programs, subject to limitations noted herein. I know of no health reason(s), other than the information indicated on this form, why I or my daughter should not participate in any of the American Heritage Girls activities. I hereby give permission for the AHG Troop 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 Troop Ministry Team or Charter Organization to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if Member/participant is an adult), except as noted. I agree to the release of records necessary for treatment. Notes:

_____

_____

_____

_____

Date _____Signature of Parent/Guardian or Adult _____

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

Date _____ Signature of Parent/Guardian or Adult _____