



**GIRL SCOUTS OF WESTERN NEW YORK, INC.**

**ADULT HEALTH STATEMENT**  
*PLEASE FILL OUT THIS FORM COMPLETELY*

Last Name:		First Name:		MI:
Address:		City:	State:	Zip:
Phone (home):	Phone (cell):		Email:	

<b>IN CASE OF EMERGENCY NOTIFY:</b>	<b>IF CANNOT BE REACHED, NOTIFY:</b>
Name:	Name:
Phone Number (s):	Phone Number (s):
Address:	Address:
Relationship:	Relationship:

<b>HEALTH INSURANCE</b>	
Type of Insurance:	Insurance #:
Does your insurance require a pre-approval phone call? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Doctor's Name:	Doctor's Phone Number:

<b>CONFIDENTIAL HEALTH HISTORY</b>	
	If yes, please explain your condition further:
Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, do you take insulin?
Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of most recent tetanus shot: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments on any other health factors to which we should be alerted?	

<b>MEDICATION:</b>
Are you on any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
State medication(s) and dosage(s):

This health statement is complete and true to the best of my knowledge. I also understand that this information will be shared on a need-to-know basis with appropriate medical personnel. I hereby give permission for the adult in charge to secure the services of a licensed physician, if necessary and to give proper treatment for any injury or illness that is deemed necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_