



**AMERICAN
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American Heritage Girls, Inc. Health and Medical History Form

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

Place Photo
Here

Member Information

Member Name: _____

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

Weight: _____ Height: _____

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 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:

	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 Administration of Medication form must be completed.

Medicine Name	Dose	Time	Reason taking/instructions

Over the Counter/As-Needed Medications

The following are Over the Counter (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	
Acetaminophen Ibuprofen	Fever, Headache or Discomfort	YES NO	
Caladryl Hydrocortisone Cream	Insect Bites or Plant Reactions	YES NO	
Chloraseptic Throat Drops	Sore Throat	YES NO	
Pepto Bismol	Upset Stomach	YES NO	
Tums	Upset Stomach	YES NO	
Peroxide	Wounds (Cuts, abrasions, etc.)	YES NO	
Neosporin	Wounds (Cuts, abrasions, etc.)	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.

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/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 _____



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Request for Administration of Medication

Please attach to the AHG Health and Medical History Form and update as necessary.

Name of Member: _____ Date of Birth: _____

Address: _____

Diagnosis: _____

Reason Medication must be given at an AHG event: _____

Name of medication: _____

Dose: _____ Time to be given: _____

Dates to be given: _____

Instructions: _____

Contraindications: _____

Side Effects: _____

Treatment of Side Effects/Action to be taken: _____

Is any restriction on activity necessary? Yes _____ No _____

If yes, describe: _____

Is the AHG member on any other medications? Yes _____ No _____

If yes, name of medication: _____

Print Doctor's Name: _____

Address: _____ Phone: _____

YES/NO This is an emergency medication (i.e. inhaler, epi-pen) and must be kept on child's person.

I authorize selected AHG personnel to administer the above prescription medication as prescribed by my health care provider. If the medication is an over-the-counter medication I authorize its use according to the provided instructions. I authorize the Troop Leader to contact my child's health care provider as needed regarding this medication and/or my child's response.

Parent Signature _____ Date: _____

Telephone: _____ Emergency number: _____



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High Adventure Activity Medical Form

This form is valid for 12 months.

This form should be kept at the Troop level.

Please attach to the AHG Health and Medical History Form.

Participant Name: _____ DOB: ____/____/____ Age: _____

Emergency Contact Name: _____ Phone #: _____

Health Examination: To be completed by a Licensed Health-Care Provider

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afloat or afoot) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured.

Date of Exam: _____ Height _____ Weight _____ B.P. ____/____ Pulse _____	Vision: Normal _____ Glasses _____ Contacts _____	Hearing: Normal: _____ Abnormal: _____
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Check box if normal; circle if abnormal and give details below:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Growth, development | <input type="checkbox"/> Teeth, tonsils | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Skin, glands, hair |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skeletomuscular | <input type="checkbox"/> Head, neck, thyroid | |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Neuropsychiatric | <input type="checkbox"/> Eyes, ears, nose | <input type="checkbox"/> Abdomen, hernia, rings |
| <input type="checkbox"/> Other (specify) | | | |

Comments/Details: _____

Dietary Restrictions _____

Approved for participation in:
 ___ Hiking ___ Water Activities ___ Competitive Sports ___ All activities

Specify exceptions: _____

Recommendations (explain any restrictions OR limitations)

Is medication information on the Health and Medical History Form up to date and current? YES NO
If no, please provide updated information. Attach a separate sheet if needed.

Signature of Licensed Health Care Practitioner (AHG, Inc. allows **MD, DO, PA, CNP** to sign)

_____ Date _____

Address: _____ Phone: _____

City, State, Zip: _____

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afloat or afoot) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured.