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 _____

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: _____

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 (afoot or afloat) 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: _____

Check box if normal; circle if abnormal and give details below:

☐ Growth, development	☐ Teeth, tonsils	☐ Genitourinary	☐ Skin, glands, hair
☐ Respiratory	☐ Skeletomuscular	☐ Head, neck, thyroid	
☐ Cardiovascular	☐ Neuropsychiatric	☐ Eyes, ears, nose	☐ Abdomen, hernia, rings
☐ 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 (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured.