ADULT HEALTH EXAMINATION RECORD

This part to be filled in by adult and reviewed with physician at the time of examination

Name (Last, First, Initial)				Sex	Birth
Address	**City or Town**	**State**	**Zip**	**Phone**	
				( )	
In Emergency Notify	**Address**		**Relationship**	**Phone**	
				( )	

Insurance Information, please complete the following:

Carrier	ID Number	Group Number
Member Services Phone Number	**Address**	

Health History: (Check if you have had any of the following)

❑ Eyesight Impairment	❑ Disease of Kidneys	❑ Arthritis	❑ Disease of Ears
❑ Hearing Impairment	❑ Heart Disease	❑ Diabetes	❑ Intestinal Disorders
❑ Speech Impairment	❑ Rheumatic Fever	❑ Tuberculosis	❑ Chicken Pox
❑ Disorders of Nervous System	❑ Abnormal Blood Pressure	❑ Hernia	❑ Measles
❑ Sinusitis	❑ Mental or Emotional Disorders	❑ Asthma or Hay Fever	❑ Mumps
❑ Lyme Disease	❑ Severe Menstrual Pain	❑ Other serious allergies	❑ German Measles
			❑ Other

Have you been hospitalized in the last five years? ? Yes ? No. Are you taking any medication? Explain.

If you have checked or answered yes to any of the above, give nature, dates, period of any disability and results:

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN BELOW— INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

I certify that to the best of my knowledge this health history is complete and accurate. I am in good health and able to participate in this event/assignment.

Signature of Applicant: **Date:**

HEALTH INFORMATION PRIVACY STATEMENT

The **Adult Health Examination Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative.

I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

SIGNATURE: _____ DATE: _____

(Participant)

Adult Health Examination Record —2

Name_____ **Date:** _____

Physician— Please complete remainder of application.

Instructions: Please ask applicant to show you a written description of the event/assignment so that you may determine whether she/he is in condition to participate in this particular event/assignment and to insure that the applicant has the valid immunization required.

Examination Findings— check box if condition is satisfactory. If not, explain in space provided below.

❑ Eyes and vision ❑ Skin ❑ Throat	❑ Ears and Hearing ❑ Heart ❑ Lungs	❑ Menstrual Pain ❑ Legs (for camping and primitive conditions)	❑ Abdomen ❑ Chest X-ray (if required) ❑ Other

Exact Measurement of:

Blood Pressure	Pulse Rate	Urinalysis: SP Gravity	Sugar	Albumin	Blood Hemoglobin	Height	Weight

- Does applicant have any condition which might limit activity for this event/assignment?
- Does applicant have any chronic diseases? ? Yes ? No
- If overweight, will condition restrict activity? ? Yes ? No
- Does applicant have any condition which might limit her/his participation in swimming, hill climbing and other strenuous activities? ? Yes ? No

If any of the above were unsatisfactory, or if applicant has any limitations, use this space to explain.

Immunizations — Fill in date of valid immunizations applicant has had. Only those requested on the announcement of the event are required.

Immunization	Date Last Received	Immunization	Date Last Received
Hepatitis B		Typhoid and Paratyphoid	
Tetanus (within 10 years)		Cholera	
Typus		Yellow Fever	
Polio—complete series or booster required		Gama Globulin (Hepatitis)	
Rocky Mt. Spotted Fever (entire series)		Other—	
German Measles (Rubella)			

Statement of Physician:

? Applicant is in good physical condition and able to participate in this event/assignment.

? Applicant should not participate in this event for the following reasons:

_____

Name of Physician **Signature** **Address** **Date**