



**American Heritage Girls, Inc.**

175 Tri-County Parkway, Suite 100

Cincinnati, OH 45246

513-771-2025 (fax) 513-771-2595

**Adult Health and Medical History Form**

*(This form kept at the Troop level.)*

Adult Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Work phone: \_\_\_\_\_

Spouse's place of employment: \_\_\_\_\_ Work phone: \_\_\_\_\_

In the event of an emergency, notify:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's address: \_\_\_\_\_

Dentist's name: \_\_\_\_\_

Dentist's address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medical Insurance Coverage: \_\_\_\_\_

Policy #: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

**ALLERGIES:** Food, medicines, insects, plants, other \_\_\_\_ Yes \_\_\_\_ No

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## GENERAL HEALTH INFORMATION:

(Please circle the answer that best describes your medical history.)

Asthma	YES	NO	Hearing impairment	YES	NO
Cancer/Leukemia	YES	NO	Heart Disease	YES	NO
Contacts/glasses	YES	NO	Hemophilia	YES	NO
Convulsions/Seizures	YES	NO	High Blood Pressure	YES	NO
Diabetes	YES	NO	Kidney Disease	YES	NO
Emotional disturbances	YES	NO	Menstrual Cramps	YES	NO
Ear infections	YES	NO	Migraine Headaches	YES	NO
			Motion sickness	YES	NO
Fainting	YES	NO	Nose bleeding	YES	NO

Explain any "YES" answers:

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List any medications prescribed by a physician that are to be taken on a regular basis:  
(Fill out the medication form if applicable)

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## IMMUNIZATIONS:

Year primary series completed

Year of last booster

DPT \_\_\_\_\_

\_\_\_\_\_

Measles \_\_\_\_\_

\_\_\_\_\_

Mumps \_\_\_\_\_

\_\_\_\_\_

Rubella \_\_\_\_\_

\_\_\_\_\_

Oral Polio \_\_\_\_\_

\_\_\_\_\_

Tetanus Shot \_\_\_\_\_

\_\_\_\_\_

Tuberculin Test: Type: \_\_\_\_\_ Year last given: \_\_\_\_\_ Result: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

I know of no health reason(s), other than the information indicated on this form, why I should not participate in any of the American Heritage Girls activities.

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