



Troop #

ADULT Member/Participant Health and Medical Record

Participant's Name _____ Date of birth _____ Age _____
(MM/DD/YYYY)

Address _____

City _____ State _____ Zip _____ Phone # _____

Troop Leader _____

Emergency Contacts:

Name _____ Relationship _____

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

Health/accident insurance information:

Participant does not have health care coverage at this time (Please skip to next section – Physician Information)

Participant has health care coverage as listed below

Health/accident insurance company _____ Policy # _____

Policy Holder _____ Group # _____ Effective Date _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD.

Physician Information:

Primary Care Physician _____ Phone # _____

Physician's address _____

Dentist's name _____ Phone # _____

Preferred Hospital _____

ALLERGIES	Please list all known allergies including those to medications, food and environment. If none known, please write "none known". Attach additional page to this form if needed.
Allergy to:	Normal reaction and management of the reaction:



Full Name:

Emergency Contact #:

Troop #:

HEALTH HISTORY		Do you currently have, or have you ever been treated for any of the following?			
Yes	No	Condition			Explain
		Asthma	Last attack: (MM/YY)		
		Diabetes	Last HbA1c: (Percentage)		
		Hypertension (high blood pressure)			
		Heart disease/heart attack/chest pain/heart murmur			
		Stroke/TIA			
		Lung/respiratory disease			
		Ear/sinus problems			
		Muscular/skeletal condition			
		Psychiatric/psychological and emotional difficulties			
		Behavioral/neurological disorders			
		Bleeding disorders			
		Fainting spells			
		Thyroid disease			
		Kidney disease			
		Sickle cell disease			
		Seizures	Last seizure: (MM/YY)		
		Sleep disorders (e.g., sleep walking, sleep apnea)	Use CPAP?		
		Abdominal/digestive problems			
		Surgery	Last surgery: (MM/YY)		
		Serious injury			
		Excessive fatigue or shortness of breath with exercise			
		Other			



Full Name:

Emergency Contact #:

Troop #:

IMMUNIZATIONS		The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY).				
Yes	No	Immunization	Date of Immunization	Please indicate if you have had the disease		Date of Disease
			(MM/YY)	Yes	No	(MM/YY)
		Tetanus				
		Pertussis				
		Diphtheria				
		Measles				
		Mumps				
		Rubella				
		Polio				
		Chicken Pox				
		Hepatitis A				
		Hepatitis B				
		Meningitis				
		Influenza				
		Other (i.e., HIB)				
		Exception to immunizations claimed (form required)				

MEDICATIONS		List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. If none, please write "None" below.			
Medication	Strength	Frequency	Approximate Date Started	Reason	

Administration of the above medications is approved by (if required by your state):

Adult participant signature

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You **SHOULD NOT STOP** taking any maintenance medication unless instructed to do so by your doctor.



Full Name:

Emergency Contact #:

Troop #:

I understand that, if any information I have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

This Health and Medical Record is correct and complete, as far as I know. I hereby give permission for Trail Life USA leadership to administer prescribed and noted over the counter medications in the event that I am personally unable to do so.

In case of emergency, I understand every effort will be made to contact my spouse or next of kin. In the event that they cannot be reached, I hereby give my permission to the licensed health-care provider selected by the HICKUSA adult leader(s) to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for me, except as noted below. I agree to the release of records necessary for treatment.

Notes:

Participant's name

Participant's signature

Date

This Health and Medical Record is valid for 12 calendar months.

