Adult Medical and Release Form

girl scouts of western ohio

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Insurance Company: _____ Member ID #: _____

Group ID #: _____ Insured Name: _____

Emergency Contacts

Name: _____ Relationship to Participant: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship to Participant: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please list any conditions that a first-aid or health provider would need to know such as?

Allergies: _____

_____

_____

Medications: _____

_____

_____

Chronic Illnesses, injuries or limitations: _____

_____

_____

My immunizations are up to date: ◯ Yes ◯ No

	Year Primary Series completed	**Date of Last Booster**
Diphtheria/Whooping Cough/Tetanus		
(D.T. P.) Tetanus (TD)		
Measles/Mumps/Rubella (MMR)		
Oral Polio		
Tuberculin Test (Most recent)		

In the event that reasonable attempts to contact my designated person in an emergency have not been successful, I hereby give my consent for the administration of any treatment deemed necessary by medical personnel. This health history is complete and accurate.

_____ _____

Signature of Participant Date