Girl Scouts of Montana and Wyoming Health History and Medical Form for Travelers

The more complete the information provided, the better we can work with individuals to ensure travelers receive needed care.

Name of Traveler: (Last, First, Middle Initial)	**Date of Birth:** (XX/XX/XXXX)		
Address:	**City:**	**St:**	**Zip:**
Parent or Guardian (minor only)**:**	**Phone:**	**Alternate Phone:**	
Parent or Guardian (minor only)**:**	**Phone:**	**Alternate Phone:**	

Emergency Contact Information:

Emergency Contact:	**Relationship:**
Phone:	**Alternate Phone:**

Health Insurance Information (Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply and explain in detail checked answers:

☐	Diabetes	☐	Sleep disturbances
☐	Heart Defects/Disease	☐	Fainting
☐	Asthma	☐	Bed wetting
☐	Ear Infections	☐	Constipation
☐	Musculoskeletal Disorders	☐	Chicken Pox
☐	Convulsions/Epilepsy/Seizures	☐	Measles
☐	Sinusitis (Sinus Infections)	☐	German Measles
☐	Physical Restrictions	☐	Mumps
☐	Kidney/bladder illness	☐	Rheumatic Fever
☐	Mental/psychological disorder	☐	Tuberculosis
☐	Hypertension	☐	Kidney Disease
☐	Arthritis	☐	Eating Disorders (Anorexia, Bulimia, etc.)
☐	Nosebleeds	☐	Headaches/Migraines
☐	Has begun menstruation	☐	Had surgery or hospitalized in the last 5 years
☐	Menstrual cramps	☐	Currently under doctor's care
☐	Bleeding disorder	☐	Emotional – Separation Anxiety
☐	Other:		

Please explain in detail all checked answers marked above:

Allergies: Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Does the named traveler suffer from Anaphylaxis? Yes No
Does the traveler carry an Epipen? Yes No
Does the traveler carry an inhaler? Yes No

Traveler's Name: _____

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Medications: List any medications the traveler is currently taking (or has taken in the recent past) including dosage schedule and specific instructions for use. Indicate (Yes/No) if minor is allowed to take the medication on her own or if she should be monitored by an advisor. On the trip, all medications should come in the original labeled container with specific indications for administration along with the name of the prescribed patient.

Medication	Purpose	Dosage Schedule	Specific Instructions	Self-Medicate? (Yes/No)
1.				
2.				
3.				
4.				
5.				

Over-the-Counter Medications: The traveler has permission to take over-the-counter medications in case of accident or injury. Please check all that they have permission to take:

- ☐ Tylenol/Acetaminophen
- ☐ Aspirin (fever reducer)
- ☐ Ibuprofen (pain/swelling)
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/expectorant
- ☐ Sudafed/decongestant
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Imodium (anti-diarrhea)
- ☐ Dramamine (motion sickness prevention)
- ☐ Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
- ☐ Other: _____
- ☐ Other: _____

Special considerations or notes regarding over-the-counter medications:

Does the traveler have a Special Medical or Dietary Regiment to be followed? Yes No

If yes, please explain: _____

Have you ever had any adverse reactions to general anesthetics? Yes No

If yes, please explain: _____

Any other information not covered in this form that is important for Trip Advisors to know: _____

_____

HEALTH INFORMATION PRIVACY STATEMENT

The **Health History and Medical Form for Travelers** is for health care concerns at the specified event or date(s) of travel only. All records will be handled by staff/volunteers whose job includes processing or using this information for the health benefit of the participant. All medical records will be held in limited access by the designated event or travel First Aider/Healthcare provider for the specific event. Only necessary information may be shared with staff/volunteers in order to provide adequate participant safety and health care. The designated even/trip First Aider/Healthcare provider will retain this form for seven years past the end date of the event/trip. Access to the information will be limited, but copies may be requested from the event/trip sponsor, by the participant, or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Health History and Medical Form for Travelers is complete and accurate. The named traveler has permission to engage in all prescribed activities, except as noted.

Signature of Traveler (Adult or Child): _____ **Date:** _____

Signature of Parent/Guardian (minor only): _____ **Date:** _____