Adult Health Form

Troop # _____

Name _____ Phone _____

Address _____

Family Physician _____ Phone _____

PERSONAL HEALTH HISTORY

Date of last physical _____ Date of last tetanus shot _____

Check all that applies:

☐ Hospital stay, major surgery or illness within last year. Please explain:

_____

☐ Glasses/Contacts	☐ Sinusitis	☐ Fainting
☐ Car Sickness	☐ Diabetes	☐ Hearing Problems
☐ Sleep Walker	☐ Asthma	☐ Hypoglycemia
☐ Sleep Talker	☐ Rheumatic Fever	☐ Epilepsy
☐ Poison Oak	☐ Learning Disabilities	☐ Other _____

☐ Allergies (list allergies and what is to be given)

_____

Medications – list. (Bring in bottle with original prescription). _____

_____

Dietary restrictions: _____

Disabilities – describe: _____

Medical Insurance Policy No. _____ Carrier _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

_____ _____
Signature Date

BRING THIS COMPLETED FORM TO THE EVENT