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

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:

_____

_____

_____

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

_____

_____

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 _____

AMERICAN HERITAGE GIRLS™
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High Adventure Activity Medical Form

Attach to Participant's Health and Medical Form

(Valid for 12 months from the date signed by the medical professional)

Participant Name _____ DOB: _____/_____/_____ Age _____
Emergency Contact
Name _____ Phone # _____

Health Examination

To be completed by a Licensed Health-Care Provider

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured.

Date of Exam _____
Height _____ Weight _____
B.P _____/_____ Pulse _____

Vision
Normal _____
Glasses _____
Contacts _____

Hearing
Normal _____
Abnormal _____

Check box, if normal; circle if abnormal and give details below:

- ☐Growth, development
- ☐Skin, glands, hair
- ☐Head, neck, thyroid
- ☐Eyes, ears, nose
- ☐Teeth, tonsils
- ☐Respiratory
- ☐Cardiovascular
- ☐Abdomen, hemia, rings
- ☐Genitourinary
- ☐Skeletomuscular
- ☐Neuropsychiatric
- ☐Other (specify)

COMMENTS _____

_____

_____

_____

Dietary Restrictions _____

Approved for participation in:

- ☐ Hiking
- ☐ Competitive Sports
- ☐ Water Activities
- ☐ All activities

Specify exceptions _____
_____

Recommendations (explain any restrictions OR limitations) _____
_____
_____

Is medication information on Health Form up to date and current? ☐ YES ☐ NO
If no, please provide updated information. Attach a separate sheet if needed. _____
_____
_____
_____

Signature _____ Date _____
Licensed Health-Care Practitioner

Address _____ Phone _____

City, State, Zip _____

Request for Administration of Medication

Please attach to Health Form and update as necessary

Name of Member_____Date of Birth ____/____/____

Address_____

Diagnosis_____

Reason Medication must be given at AHG event _____

_____

Name of Medication:_____

Dose: _____ Time to be given: _____

Dates to be given: _____

Instructions: Per medication instructions_____

Contraindications: _____

Side Effects: _____

Treatment of Side Effects/Action to be taken: _____

Is any restriction on activity necessary? Yes ☐ No ☐

If yes, describe: _____

Is the AHG member on any other medications? Yes ☐ No ☐

If yes, name medication: _____

Print Doctor's Name: _____

Address: _____ Phone: _____

This is an emergency medication (i.e. inhaler, epi-pen) and must be kept on child's person

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I authorize selected AHG personnel to administer the above prescription medication as prescribed by my health care provider. If the medication is an over-the-counter medication I authorize its use according to the provided instructions. I authorize the Troop Leader to contact my child's health care provider as needed regarding this medication and/or my child's response.

Parent Signature_____ Date: _____

Telephone: _____ Emergency number: _____

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____

DOB: ____/____/____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization
I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/ Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.

! **NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.** !

List participant restrictions, if any: ☐ **None**

_____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:
You must designate at least one adult. Please include a telephone number.

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____ Name: _____

Telephone: _____ Telephone: _____