



GIRL SCOUTS OF WESTERN NEW YORK

ADULT HEALTH FORM

Name _____ Telephone _____

Address _____
Street City State Zip Code

In Case Of Emergency, Notify _____
Name

Relationship City Telephone No.

Most recent physical examination. Date _____

By _____ Telephone _____ City _____

Most recent tetanus shot _____

Please complete both sides



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CONFIDENTIAL

1. Are you on any medication? _____
2. State Medication and dosage. _____
3. Reasons for medication. _____
4. Are you on a special diet? _____
5. Please explain. _____
6. Do you have any allergies? _____
7. Do you have asthma? _____
8. Are you diabetic? _____ Do you take insulin? _____
9. Do you have high blood pressure? _____
10. Comments on any other health factors or conditions to which we should be alerted?

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