girl scouts of western washington

Travel Health Form

This form is used by girls and advisors for travel of **3 or more nights**, unless travel occurs over a US Federal Holiday weekend. Please be complete in the information provided to ensure proper medical care. A medical examination must be completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months unless a health issue is present**.** For international travel, this form must be completed within 12 months. Groups traveling to Canada for less than 3 nights can forgo this form but must still complete all necessary paperwork for short trips.

Participant Information

Full Legal Name: _____ **Birthdate**: _____ **Gender**: ☐ Female ☐ Male

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

Phone Number: _____ **Email:** _____

Primary Emergency Contact:	**Secondary Emergency Contact:**
Relationship:	Relationship:
Phone 1:	Phone 1:
Phone 2:	Phone 2:

Health Insurance Information
In case of accident or illness, personal insurance is primary, Girl Scout insurance is secondary

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

Medical History
Check all that apply and explain in detail checked answers – use extra paper if necessary

☐	Diabetes	☐	Sleep Disturbances	☐	Eating Disorders (Anorexia, Bulimia)
☐	Heart Defects/Disease	☐	Eyesight Impairment	☐	Headaches/Migraines
☐	Asthma	☐	Hearing Impairment	☐	Intestinal Disorders/Constipation
☐	Diseases of the Ear or Ear Infections	☐	Speech Impairment	☐	Arthritis
☐	Musculoskeletal Disorders	☐	Chicken Pox	☐	Nosebleeds
☐	Convulsions/Epilepsy/Seizures	☐	Measles	☐	Hernia
☐	Sinusitis (Sinus Infections)	☐	German Measles	☐	Menstrual Cramps
☐	Physical Restrictions	☐	Mumps	☐	Bleeding Disorder
☐	Kidney/Bladder Illness	☐	Rheumatic Fever	☐	Had surgery/hospitalized in the last 5 years
☐	Mental/Psychological Disorder	☐	Tuberculosis	☐	Currently under doctor's care
☐	Hypertension/High Blood Pressure	☐	Kidney Disease	☐	Other:

Please explain any items checked above:

Medical Conditions and/or Concerns
Please include any precautions or restrictions on activities, as well as concerns relating to emotional and mental well-being (including self-harm, depression, effects of medication on their behavior, eating disorders, etc.). We want to provide the most supportive environment possible, and a large part of that knows what's going on with trip participants. The more information you provide, the better we are able to work with you to establish a plan.

Name of Condition	**Effects**

Additional Information or Comments:

Allergies

List ALL allergies (including medications, food, bees, etc.), the type of reaction/severity, treatment and date of last reaction.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction

Comments:

Do you suffer from Anaphylaxis?* Yes ☐ No ☐

*A severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Do you carry an Epipen? Yes ☐ No ☐ **Do you carry an inhaler? Yes ☐No ☐**

Medications

*List any medications you are currently taking including dosage schedule and specific instructions for use. Prescriptions must be in the original container with appropriate label. Please provide extra written prescription(s) from the doctor with the **generic name** for all medications in case the original prescription is lost or a new one needs to be obtained.*

☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐		☐	
☐			

Other:

Special considerations or notes:

Additional Medical/Dietary Information

Do you have a Special Medical or Dietary Regiment to be followed? Yes ☐ No ☐
If so, please explain:

Have you ever had any adverse reactions to general anesthetics? Yes ☐ No ☐
If so, please explain:

Any other information not covered in this form that is important that advisors for this trip should know about - use additional sheet if necessary?

Medical Examination Form: *Must be completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 12-24 months, unless a health issue is present.*

To be completed by Trip Advisors or Trip Participant:

Trip/Activity:	
Region/Location:	**Date Range of Trip/Activity:**
Distance from Emergency Medical Services:	**Level of First Aid Required:**
Trip/Activity Description: *Include a brief description of your trip. This will help the medical professional evaluate your physical readiness for the trip. Please note if different activities will be done (ex. rock climbing, exploring cultural sites, etc.)*	

Medical Examination
To be completed by healthcare provider

Height:_____ Weight: _____ Blood pressure: _____/_____ Pulse Rate: _____

Hearing: R _____ L _____ Eyes: With Glasses R 20/_____ L 20/_____ Without Glasses R 20/_____ L 20/_____

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

_____ Nose	_____ Abdomen	_____ Urinalysis	_____ Musculoskeletal
_____ Throat	_____ Hernia	_____ HGB	_____ General Emotional State
_____ Teeth	_____ Genitalia	_____ Skin	_____ General Physical State
_____ Heart	_____ Appearance/Nutrition		Other: _____
_____ Lungs			

Record of Immunization
Must be completed in detail, or a copy of a current immunization record may be attached to this form

Immunization	Date Series Completed	Year of Last Booster	Immunization	Date Series Completed	Year of Last Booster
Hep B			Typhoid		
DTap/Tdap			Paratyphoid		
DT/Td			Cholera		
Hib			Yellow Fever		
IPV/OPV			Typhus		
PCV7			Rocky Mountain		
MMR			Spotted Fever		
Varicella			HPV		
TIV/LAIV			Rota		
Hep A			MCV4/MPSV4		

Tuberculin Test: Year last given: _____ Result: _____

Physician Information

Licensed Physician Name:	Licensed Physician Name:
Address:_____ City:_____ ST:_____ Zip:_____	

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

Signature of Licensed Physician: _____ State License Number: _____ Date: _____