



ADULT EMERGENCY MEDICAL INFORMATION

Today's Date: _____
(This form must be updated each year.)

(Troop Use Only)

Name _____ Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth _____

Last tetanus toxoid booster (date) _____ Blood type _____

Allergies to drugs or food _____

Any special medication or pertinent information, limitations for activities: _____

Telephone where emergency contact may be reached:

Name _____ Phone (home) _____ Phone (business) _____

Name _____ Phone (home) _____ Phone (business) _____

Family Physician

Name _____ Address _____

City State, Zip _____

Office Phone _____ After Hours Phone _____

Family Insurance Company _____ Policy Number _____

Medical History

Has you ever been treated for any of the following:

- Rheumatic fever
- Heart Disease
- Asthma
- Epilepsy
- Chronic disease of the lungs
- Chronic ear disease
- Disease of the bone or joint

Other (please specify) _____

Do you have any known defect of vision or hearing? Yes No
If yes, explain: _____

Do you wear contact lenses? Yes No

Date of last physical examination: _____

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Adult Medical Release

I _____ hereby give my permission to receive emergency medical or surgical treatment and to be hospitalized if necessary.

In no event will Girl Scouts of Utah, its officers, leaders, or agents be held liable for any first aid rendered or treatment, drugs and medicines, or surgical procedures performed pursuant to this consent.

Signed _____
My signature