

Each year, AHG Girl and Adult Members must complete a new *Health and Medical Form* to be kept on file at the Troop level.

Attaching a photo to this form can help to avoid errors in identification.

Member Name			
Date of birth		Age	
Weight		Height	
Street Address			
City, State Zip			
Parent/Guardian Name(s)			
Phone Number(s)			
Emergency Contacts	Name		
	Relationship		
	Phone Number		
	Name		
	Relationship		
	Phone Number		
Allergies: If applicable, please list all known allergies including medications, food, and environment.	Allergy	Normal reaction and management of reaction	
General Health Information: Check all that apply, past or present, to this member's health history.	<input type="checkbox"/> Abdominal/stomach/digestive problems <input type="checkbox"/> Asthma <input type="checkbox"/> Convulsions/seizures <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive fatigue <input type="checkbox"/> Fainting or dizziness <input type="checkbox"/> Head injury/concussion <input type="checkbox"/> Heart disease/heart attack/chest pain/heart murmur/coronary artery disease <input type="checkbox"/> Hemophilia or blood disorders <input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Lung/respiratory disease <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Migraines/headaches <input type="checkbox"/> Motion/altitude sickness <input type="checkbox"/> Muscular/skeletal conditions/muscle or bone issues <input type="checkbox"/> Neurological disorders <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus problems <input type="checkbox"/> Sleep apnea, sleepwalking or sleep disorders <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Thyroid disease	

Member Name					Troop Number	
Additional notes about this member's behavior, physical, emotional or mental health needs pertinent to their participation in American Heritage Girls.						
Medications: If medications of any type will be taken or needed during Troop meetings, events, activities or trips, please fill out the <i>Request for Medication Administration Form</i> .	<input type="checkbox"/> No medications are routinely taken.					
	<input type="checkbox"/> The medications listed below are regularly taken (including inhalers, Epi-Pens, over the counter medications, homeopathic, and prescription medications). If additional lines are needed, please attach a separate page.					
	Medication		Dosage		Reason for medication	
Tetanus Immunization Policy: AHG requires members to have Tetanus immunization within the last 10 years.	<input type="checkbox"/> I (or my daughter) has received tetanus immunization on _____(date).					
	<input type="checkbox"/> I (or my daughter) have not received tetanus immunization and I would like to request exemption based upon a lack of immunization records, religious, philosophical or medical grounds. Signature of individual or parent/guardian: _____					
Immunizations: The following immunizations are recommended by AHG, Inc. but are not required.	Type	Year Received	Type	Year Received	Type	Year Received
	Pertussis		Polio		Hepatitis B	
	Diphtheria		Chicken pox		Meningitis	
	MMR		Hepatitis A		Influenza	
I give permission for full participation in American Heritage Girls programs, events and activities, subject to limitations noted herein. I know of no health reason(s), other than the information indicated in this form, why I or my daughter should not participate in any of the American Heritage Girls activities. Please check one: <input type="checkbox"/> In case of an emergency, I understand every effort will be made to contact me (or my next of kin). In the event that contact cannot be made, I hereby give my permission to the licensed health-care provider selected by my Troop or Charter Organization to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for myself or my child, except as noted. I agree to the release of records necessary for treatment. <input type="checkbox"/> I do not give my consent for medical treatment of my daughter or I. In the event of illness or injury requiring treatment, I wish AHG volunteers to take no action beyond basic first-aid measures						
Additional notes:						
Signature of individual or parent/guardian					Date	