

Each year, AHG Girl and Adult Members complete a new or update an existing *Health and Medical Form* kept on file at the Troop level.

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

<b>Member Name</b>			
<b>Date of birth</b>		<b>Age</b>	
<b>Weight</b>		<b>Height</b>	
<b>Street Address</b>			
<b>City, State Zip</b>			
<b>Parent/Guardian Name(s)</b>			
<b>Phone Number(s)</b>			
<b>Emergency Contacts</b>	<b>Name</b>		
	<b>Relationship</b>		
	<b>Phone Number</b>		
	<b>Name</b>		
	<b>Relationship</b>		
	<b>Phone Number</b>		
<b>Allergies:</b> If applicable, please list all known allergies including medications, food, and environment.	<b>Allergy</b>	<b>Normal reaction and management of reaction</b>	
<b>General Health Information:</b> 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	

<b>Member Name</b>					<b>Troop Number</b>	
Additional notes about this member's behavior, physical, emotional or mental health needs pertinent to their participation in American Heritage Girls.						
<b>Medications:</b> 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.					
	<b>Medication</b>		<b>Dosage</b>		<b>Reason for medication</b>	
<b>Tetanus Immunization Policy:</b> 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: _____					
<b>Immunizations:</b> The following immunizations are recommended by AHG, Inc. but are not required.	<b>Type</b>	<b>Year Received</b>	<b>Type</b>	<b>Year Received</b>	<b>Type</b>	<b>Year Received</b>
	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 <b>do not</b> 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 <b>no action</b> beyond basic first-aid measures						
<b>Additional notes:</b>						
Signature of individual or parent/guardian					Date	