Girl Scouts

GIRL HEALTH EXAMINATION RECORD

This part to be filled in by parent and reviewed with physician at the time of examination

Name (Last, First, Initial)			Parent or Guardian			Phone	
						( )	
Address	City or Town		State	Zip	Birth	Age	Sex
In Emergency Notify			Address			Phone	
						( )	

Insurance Information, please complete the following:

Carrier	ID Number	Group Number
Member Services Phone Number	**Address**	

Health History: (Check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions From Parent:
☐ Chicken Pox	☐ Animals__________	☐ Ear Infections	My daughter has permission to take or use the following:
☐ Measles	☐ Food __________	☐ Heart Defect/Disease	{ }Tylenol/Acetaminophen
☐ German Measles	☐ Hay Fever __________	☐ Seizures	{ }Advil/Ibuprofen
☐ Mumps	☐ Insect Stings ________	☐ Bleeding Disorders	{ }Sudafed/decongestant
☐ Rheumatic Fever	☐ Medicine/Drugs ______	☐ Asthma	{ }Benadryl/antihistamine
☐ Tuberculosis	☐ Plants __________	☐ Hypertension	{ }Pepto Bismol
☐ Kidney	☐ Pollen __________	☐ Diabetes	{ }Tums/antacid
	☐ Other (specify)_______	☐ Musculoskeletal Disorders	{ }Robitussin/expectorant
		☐ Arthritis	{ }Swimmers' Ear/alcohol-vinegar solution
		☐ Sinusitis	
		☐ Other________	

Please describe conditions and give dates:

Operations or serious injuries:____

Hospitalizations: ____

Other diseases/disabilities: ____

Comments where applicable:

Fainting____________________________ Sleep disturbances ____________________

Bed wetting _________________________ Menstrual cramps ____________________

Constipation ________________________ Nosebleeds ________________________

Emotional disturbances __________________ Other ___________________________

Specific activities to be encouraged __________ Restricted________________________

Special medical or dietary regimen to be followed (specify)______________________________

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.

Signature of Parent/Guardian________________________ **Date** ____________________

GIRL HEALTH EXAM RECORD-2

Name: ______________________________ **Date:** ____________________

(This part to be filled in by physician after review of health history with parent/guardian.)

Health Examination:

Height ________ **Weight** ________ **B.P.** ________

Appearance-Nutrition ____________________

	Without Glasses		With Glasses	
Eyes	R 20/ ____	L 20/ ____	R 20/ ____	L 20/ ____

Ears __________ **Hearing R** ______ **L** ______

Code: Satisfactory =S | Not satisfactory = NS | Not examined = NE

Nose __________ **Throat** __________

Teeth __________ **Heart** __________

Lungs __________ **Abdomen** __________

Genitalia __________ **Hernia** __________

Skin __________ **Musculoskeletal** __________

General physical and emotional status __________

Urinalysis* __________ **HGB*** __________

Other notes ______________________________

Physician's comments and recommendations
Give details or indicate management or significant illnesses.

*Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty.

Record of Immunization:

Immunization	Year Primary Series Completed	Year Of Last Booster
DTaP		
Diphtheria		
Pertussis (Whooping Cough)		
Tetanus (within last 10 years)		
Td		
Oral polio/IPV		
Measles		
Mumps		
Rubella		
Hib		
Hep B		
Tuberculin test	Yr. last given ____	Result ____
Other		
Typhoid and Paratyphoid		
Cholera		
Yellow Fever		
Typhus		
Rocky Mountain Spotted Fever		

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

Licensed physician's name: ____________________

Licensed physician's signature: ____________________

Address ____________________

City __________ **State** __________ **Zip** ______

Phone(_______) __________ **Date** __________

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN ON SEPARATE PAPER AND ATTACH— INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

HEALTH INFORMATION PRIVACY STATEMENT

The **Girl Health Examination Record** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health form will be retained by the sponsoring council or GSUSA until it is destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

SIGNATURE: ______________________________ DATE: ________________
(Parent/guardian)