



Girl Scouts.

Girl Scouts of the Missouri Heartland, Inc. Adult Health Examination Record

(to be filled in by adult and reviewed at time of examination)

Name _____ Date of Birth _____
(Last) (First) (Middle Initial)

Age _____ Sex _____ Phone (_____) _____ Address _____

City _____ County _____ State _____ Zip _____

In an emergency, notify _____ Relationship _____

Address _____ Phone (_____) _____

Insurance Information

Carrier _____ ID Number _____ Group Number _____

Member Services Phone Number (_____) _____ Address _____

Health History (Check those that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Eyesight Impairment | <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Disease of Ears |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Mental or Emotional Disorders | <input type="checkbox"/> Intestinal Disorders |
| <input type="checkbox"/> Speech Impairment | <input type="checkbox"/> Severe Menstrual Pain | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Disorders of Nervous System | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Disease of Kidneys | <input type="checkbox"/> Hernia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma or Hay Fever | _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other serious allergies | _____ |

If you have checked of any of the above, please provide nature, dates, period of any disability and results: _____

Have you been hospitalized in the last five years? Yes No Explain _____

Are you taking any medication? Yes No
Please list current medications below, including dosage and any potential harmful interactions (e.g., food, other medications, environmental, etc.) _____

I certify that to the best of my knowledge this health history is complete and accurate. I am in good health and able to participate in this event/assignment.

Adult Participant Signature _____ Date _____

Health Information Privacy Statement

The *Adult 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. 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.

Adult Participant Signature _____ Date _____

(This page is to be filled in by physician.)

Note to physician: Please ask applicant to show you a written description of the event/assignment so that you may determine whether she/he is in condition to participate in this particular event/assignment and to ensure that the applicant has the valid immunizations required.

Health Examination

Please check the box to indicate satisfactory findings:

- Eyes and vision
- Heart
- Abdomen
- Skin
- Lungs
- Chest X-ray (if required)
- Throat
- Menstrual Pain
- Other _____
- Ears and Hearing
- Legs (for camping & primitive conditions) _____

Does applicant have any condition which might limit activity for this event/assignment? Yes No

Does applicant have any chronic diseases? Yes No

If overweight, will condition restrict activity? Yes No

Does applicant have any condition which might limit her/his participation in swimming, hill climbing and other strenuous activities? Yes No

Explanation of any unsatisfactory findings _____

Measurements

Height _____ Weight _____ BP _____ Pulse Rate _____

Urinalysis: SP _____ Gravity _____ Sugar _____ Albumin _____

Blood Hemoglobin _____

Record of Immunizations

Immunization

Date Last Received

Hepatitis B	_____
Tetanus (within 10 years)	_____
Typhus	_____
Polio—complete series or booster required	_____
Rocky Mt. Spotted Fever (entire series)	_____
German Measles (Rubella)	_____
Typhoid and Paratyphoid	_____
Yellow Fever	_____
Gama Globulin (Hepatitis)	_____
Cholera	_____
Other _____	_____

Statement of Physician

- Applicant is in good physical condition and able to participate in this event/assignment.
- Applicant should not participate in this event for the following reasons: _____

Physician's name _____ Signature _____ Date _____

Phone (_____) _____ Address _____

City _____ County _____ State _____ Zip _____

