



Girl Scouts of the Missouri Heartland, Inc.

Girl Health History/Examination Record

Girl Scouts. (first page to be filled in by parent and reviewed at time of examination)

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

Age _____ Sex _____ Parent(s) or Guardian(s) _____

Phone (_____) _____ Address _____

City _____ County _____ State _____ Zip _____

In an emergency, notify _____

Address _____ Phone (_____) _____

Health History (Check those that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Diseases | <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic or Recurring Illnesses |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Animals | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Food | <input type="checkbox"/> Heart Defect/Disease |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Bleeding Disorders |
| | <input type="checkbox"/> Medicine/Drugs | <input type="checkbox"/> Asthma |
| | <input type="checkbox"/> Plants | <input type="checkbox"/> Hypertension |
| | <input type="checkbox"/> Pollen | <input type="checkbox"/> Diabetes |
| | | <input type="checkbox"/> Musculoskeletal Disorders |
| | | <input type="checkbox"/> Other (Specify) _____ |

Please describe conditions and give dates _____

Operations or serious injuries _____

Hospitalizations _____

Other diseases/disabilities _____

Suggestions from parent _____

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 _____

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. I understand the information on this form will be shared only with my daughter's counselors and the camp administration. The camp staff will make every effort to protect personal health information and will only disclose such information to healthcare professionals providing treatment.

Signature of Parent/Guardian _____ Date _____

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

Health Examination

Date of Examination _____ Height _____ Weight _____ BP _____

Appearance-Nutrition _____

Vision without Glasses: R 20/_____ L 20/_____ Vision with Glasses: R 20/_____ L 20/_____

Color Vision _____ Ears _____ Hearing: R _____ L _____

Code: Satisfactory
Not satisfactory x
Not examined

Nose _____

Throat _____

Teeth _____

Heart _____

Lungs _____

Abdomen _____

Genitals _____

Hernia _____

Skin _____

Musculoskeletal _____

General physical and emotional status _____

Other notes _____

Record of Immunizations

Immunization

**Year Primary
Series Completed**

**Year Of
Last Booster**

D.P.T. (Diphtheria, Tetanus,
Pertussis (Whooping Cough))

Td _____

Oral Polio _____

Measles _____

Mumps _____

Rubella _____

Hib _____

Hepatitis B _____

Other _____

Tuberculin test Year last given _____

Result _____

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

Licensed physician's name _____

Licensed physician's signature _____ Date _____

Phone (_____) _____ Address _____

City _____ County _____ State _____ Zip _____

