Girl Scouts of the Missouri Heartland, Inc.

Girl Health Examination Record

(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*)

☐ Diseases
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Measles

☐ Allergies
- ☐ Animals
- ☐ Food
- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Medicine/Drugs
- ☐ Plants
- ☐ Pollen

☐ Chronic or Recurring Illnesses
- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Seizures
- ☐ Bleeding Disorders
- ☐ Asthma
- ☐ Hypertension
- ☐ Diabetes
- ☐ Musculoskeletal Disorders
- ☐ 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 ______________