Girl Scouts.

GIRL HEALTH EXAMINATION RECORD

To Be Filled in By Parent And Reviewed At The Time Of Examination

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

Health History: (Check those that apply)

___Diseases
___Chicken Pox
___Measles
___German Measles
___Mumps

___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 (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 _____

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

Health Examination:
Date of Examination_____
Height _____ Weight _____ BP _____
Appearance-Nutrition _____

	Without Glasses	With Glasses
Eyes R 20/_____ L 20/ _____	R 20/_____	L 20/_____
Ears _____	Hearing R _____	
Color Vision _____	L _____	

Code: Satisfactory ✓
Not satisfactory X
Not examined o

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.T.P.	_____	_____
Diphtheria		
Pertussis (Whooping Cough)		
Tetanus		
Td	_____	_____
Oral Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hib	_____	_____
Hep B	_____	_____
Tuberculin test	Year last given _____	
	Result _____	
Other	_____	_____

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 _____
(Area Code) Phone _____ Date _____