Girl Scouts of the Missouri Heartland, Inc.

Girl 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 _____

Emergency Information

In case of emergency, contact: _____ Relationship _____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

Name of Physician _____ Phone ( ) _____

Family Medical Center/Preferred Hospital _____

Health History (*Check those that apply*)

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

Allergies
- ☐ Animals
- ☐ Foods
- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Medicines/Drugs
- ☐ Plants
- ☐ Pollen
- ☐ Other serious allergies

Chronic or Recurring
- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Seizures
- ☐ Bleeding Disorders
- ☐ Asthma
- ☐ Hypertension
- ☐ Diabetes
- ☐ Other (Specify Below)

Please describe conditions and give dates: _____

_____

Operations or serious injuries _____
Hospitalizations _____
Other diseases/disabilities _____

Suggestions from parent/guardian _____

_____

_____

Comments where applicable

Fainting _____ Sleep disturbances _____
Bed wetting _____ Menstrual cramps _____
Constipation _____ Nosebleeds _____
Emotional disturbances _____ Other _____

Specific activities to be encouraged _____
Specific activities to be restricted _____

Special medical or dietary regimen to be followed _____

_____

This health history is complete and accurate. My Girl Scout 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 Girl Scout'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 _____