

GIRL HEALTH EXAMINATION RECORD

This part to be filled in by parent and reviewed with physician at the time of examination

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

Insurance Information, please complete the following:

Carrier	ID Number	Group Number
Member Services Phone Number	Address	

Health History: (Check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions From Parent
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney	<input type="checkbox"/> Animals <input type="checkbox"/> Food <input type="checkbox"/> Hay Fever <input type="checkbox"/> Insect Stings <input type="checkbox"/> Medicine / Drugs <input type="checkbox"/> Plants <input type="checkbox"/> Pollen <input type="checkbox"/> Other	<input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorder <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other	My daughter has permission to take or use the following: <input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Advil/Ibuprofen <input type="checkbox"/> Sudafed/decongestant <input type="checkbox"/> Benadryl/antihistamine <input type="checkbox"/> Pepto Bismol <input type="checkbox"/> Tums/antacid <input type="checkbox"/> Robitussin/expectorant <input type="checkbox"/> Swimmer's Ear/ alcohol-vinegar solution

Please describe conditions and give dates:

Operations or serious injuries
 Hospitalizations
 Other diseases/disabilities

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** _____

Name: _____ Date _____

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

Health Examination		Record of Immunization			
Height	Weight	B.P.	Immunization	Year Primary Series Completed	Year of Last Booster
Appearance- Nutrition			DTaP		
Without Glasses		With Glasses	Diphtheria		
R 20 /		R 20 /	Pertussis (Whooping Cough)		
L 20 /		L 20 /	Tetanus (within last 10 years)		
Ears			Td		
Hearing R		L	Oral polio/IPV		
Code: Satisfactory=S Not Satisfactory=NS Not Examined=NE			Measles		
Nose		Throat	Mumps		
Teeth		Heart	Rubella		
Lungs		Abdomen	Hib		
Genitalia		Hernia	Hep B		
Skin		Musculoskeletal	Tuberculin test	Yr. last given	Results
General physical and emotional status			Other		
			Typhoid & Paratyphoid		
Urinalysis*		HGB*	Cholera		
Other notes			Yellow Fever		
			Typhus		
			Rocky Mountain Spotted Fever		
Physician's comments and recommendations. Give details or indicate management or significant illness.		This person is in satisfactory condition and my engage in all usual activities except as noted.			
		Licensed physician's name			
		Licensed physician's signature			
		Address			
		City and State		Zip	
* Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty.		Phone		Date	
		()			

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN ON SEPARATE PAPER AND ATTACH - INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

HEALTH INFORMATION PRIVACY STATEMENT

The Girl 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 retrained for sever years past the age of maturity of the participant. 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.

Signature: _____ Date _____
 (Parent / guardian)