Girl Scouts of Virginia Skyline Council

ADULT HEALTH EXAMINATION RECORD

PART 1: to be completed by ADULT PARTICIPANT and reviewed with physician at the time of examination.

Name:	
Gender	
Birthdate:	
Street Address:	
City, State, Zip	
Phone #:	
Email:	
In case of emergency, please notify:	
Emergency Contact Name:	
Emergency Contact Phone #:	
Relationship to you:	

INSURANCE INFORMATION

Carrier Name:	
ID #:	
Group #:	
Members Services Phone #:	
Carrier's Address:	

HEALTH HISTORY

Check if you have had any of the following:

☐ Eyesight impairment	☐ Disease of kidneys	☐ Arthritis
☐ Hearing impairment	☐ Heart Disease	☐ Diabetes
☐ Speech impairment	☐ Rheumatic Fever	☐ Tuberculosis
☐ Disorders of nervous system	☐ Abnormal blood pressure	☐ Hernia
☐ Sinusitis	☐ Mental or emotional disorders	☐ Asthma
☐ Lyme Disease	☐ Severe menstrual pain	☐ Hay fever
☐ Disease of ears	☐ Intestinal disorders	☐ Other serious allergies
☐ Chicken Pox	☐ Mumps	☐ Measles
☐ Other:		

If you checked YES to any of the above, please give nature, dates, period of disability, and results:

Have you been hospitalized in the last five years? ☐ YES ☐ NO

MEDICATIONS

Please list current medications being taken (include dosage and any potential harmful interactions (e.g. food, medications, environmental):

I certify that to the best of my knowledge this health history is complete and accurate. I am in good health and able to participate in this event/assignment.

Participant's Signature:	
Date:	

HEALTH INFORMATION PRIVACY STATEMENT

The Adult 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 Girl Scouts of the USA until it is destroyed. All forms/records with noted treatment will be retained for seven years. 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.

Participant's Signature:	
Date:	

PART 2: to be completed by PHYSICIAN

INSTRUCTIONS

Please ask participant to show you a written description of the event/assignment so that you may determine whether she/he is in condition to participate in this particular event/assignment and to insure that the applicant has the valid immunization required.

EXAMINATION FINDINGS

Please check box if condition is satisfactory. If not, please explain in space provided below.

☐ Eyes & vision	☐ Ears & hearing	☐ Menstrual pain
☐ Abdomen	☐ Skin	☐ Heart
☐ Throat	☐ Lungs	☐ Chest x-ray (if required)
☐ Legs (for camping & primitive conditions)		
☐ Other:		

Exact Measurements:

Blood pressure:	Pulse rate:
Urinalysis (SP gravity):	Sugar:
Albumin:	Blood hemoglobin:
Height:	Weight:

Does applicant have any condition which might limit activity for this event/assignment? ☐ YES ☐ NO

Does applicant have any chronic diseases? ☐ YES ☐ NO

If overweight, will condition restrict activity? ☐ YES ☐ NO

Does applicant have any condition which might limit her/his participation in swimming, hill climbing and other strenuous activities? ☐ YES ☐ NO

If any of the above were unsatisfactory, or if applicant has any limitations, use this space to explain.

IMMUNIZATIONS

Fill in date of valid immunizations applicant has had. Only those requested on the announcement of the event are required.

IMMUNIZATION	DATE LAST RECEIVED
Hepatitis B	
Tetanus (within 10 years)	
Typus	
Polio (complete series or booster required)	
Rocky Mt. Spotted Fever (entire series)	
German Measles (Rubella)	
Typhoid & Paratyphoid	
Cholera	
Yellow Fever	
Gama Globulin (Hepatitis)	
Other:	
Other:	
Other:	

STATEMENT OF PHYSICIAN

☐ Participant is in good physical condition and able to participate in this event/assignment.

☐ Participant should NOT participate in this event for the following reasons:

Physician's Name:	
Physician's Signature:	
Date:	
Address:	