Girl Scouts of Virginia Skyline Council

GIRL HEALTH EXAMINATION RECORD

PART 1: to be completed by PARENT/GUARDIAN and reviewed with physician at the time of examination.	
Girl's Name:	
Parent's/Guardian's Name:	
Gender:	
Birthdate:	
Age:	
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:

DISEASES	ALLERGIES	CHRONIC/RECURRING ILLNESSES
☐ Chicken Pox	☐ Animals	☐ Ear Infections
☐ Measles	☐ Food	☐ Heart Defect/Disease
☐ German Measles	☐ Hay Fever	☐ Seizures
☐ Mumps	☐ Insect Stings	☐ Bleeding Disorders
☐ Rheumatic Fever	☐ Medicine/Drugs	☐ Asthma
☐ Tuberculosis	☐ Plants	☐ Hypertension
☐ Kidney	☐ Pollen	☐ Diabetes
		☐ Musculoskeletal Disorders
		☐ Arthritis
		☐ Sinusitis
☐ Other:		

Please describe conditions and give dates:	
Operations or serious injuries:	
Hospitalizations:	
Other diseases/disabilities:	

Comments where applicable:	
Fainting:	
Bed wetting:	
Constipation:	
Emotional disturbances:	
Sleep disturbances:	
Menstrual cramps:	
Nosebleeds:	
Specific activities to be encouraged:	
Specific activities to be restricted:	
Special medical or dietary regimen to be followed:	
Other:	

MEDICATIONS

My daughter has permission to take or use the following:
☐ Tylenol/acetaminophen
☐ Advil/ibuprofen
☐ Sudafed/decongestant
☐ Benadryl/antihistamine
☐ Pepto Bismol
☐ Tums/antacid
☐ Robitussin/expectorant
☐ Swimmers' Ear/alcohol-vinegar solution

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.

Parent/Guardian Signature:	
Date:	

PART 2: to be completed by PHYSICIAN

GIRL HEALTH EXAM RECORD

Name:	Date:

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

HEALTH EXAMINATION

Height:	Weight:
B.P.:	Appearance/Nutrition:
Eyes (without glasses):	Right 20/_____; Left 20/_____
Eyes (with glasses):	Right 20/_____; Left 20/_____
Ears (hearing):	Right: _____; Left:_____

CODE: S = Satisfactory, NS = Not Satisfactory, NE = Not Examined	
Nose:	Throat:
Teeth:	Heart:
Lungs:	Abdomen:
Genitalia:	Hernia:
Skin:	Musculoskeletal:
General physical & emotional status:	
Urinalysis*:	HGB*:
**Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty.*	
Other Notes:	
Physician's comments and recommendations; give details or indicated management or significant illnesses.	

RECORD OF IMMUNIZATIONS

Immunization	Year Primary Series Completed	Year of Last Booster
DTaP		
Diphtheria		
Pertussis (Whooping Cough)		
Tetanus (within last 10 years)		
Td		
Oral polio/IPV		
Measles		
Mumps		
Rubella		
Hib		
Hep B		
Tuberculin Test	Year last given:	Result:
Typhoid and Paratyphoid		
Cholera		
Yellow Fever		
Typhus		
Rocky Mtn Spotted Fever		
Other: _____		

STATEMENT OF PHYSICIAN

This person is in satisfactory condition and may engage in all usual activities except as noted.

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

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

Parent's/Guardian's Signature:	
Date:	