



# Girl Scouts Heart of the Hudson, Inc.

## 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 Trp #
In Emergency Notify this contact			Relationship			
Emergency contact address				Phone ( )		Cell Phone ( )

Insurance information, please complete the following:		
Carrier	ID Number	Group Number
Insurance Company Phone Number	Address	

Health History: (Check those that apply)			
Illnesses	Allergies	Chronic or Recurring Illness	Suggestion from parent:
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Animals	<input type="checkbox"/> Ear Infections	<b>My daughter has permission to take or use the following</b>
<input type="checkbox"/> Measles	<input type="checkbox"/> Food	<input type="checkbox"/> Heart Defect/Disease	
<input type="checkbox"/> German Measles	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Insect stings	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Tylenol/Acetaminophen
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Medicine/drugs	<input type="checkbox"/> Asthma	<input type="checkbox"/> Advil/Ibuprofen
<input type="checkbox"/> Kidney	<input type="checkbox"/> Plants	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sudafed/decongestant
<input type="checkbox"/> Mumps	<input type="checkbox"/> Pollen	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Benadryl/antihistamine
	<input type="checkbox"/> Other (specify)	<input type="checkbox"/> Musculoskeletal Disorders	<input type="checkbox"/> Pepto Bismol
		<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tums/antacid
		<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Robitussin/expectorant
		<input type="checkbox"/> IBD – Irritable Bowel Disease	<input type="checkbox"/> Swimmers' Ear/alcohol vinegar solution
		<input type="checkbox"/> Other	

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 encouraged	restricted

Special medical or dietary regimen to be followed (specify)
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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 \_\_\_\_\_

# GIRL HEALTH EXAM RECORD 2

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		
Eyes	Without Glasses	With Glasses		Diphtheria		
	R 20/ L 20/	R 20/ L 20/		Pertussis (Whooping Cough)		
Ears	Hearing R	L		Tetanus (within last 10 Years)		
				Td		
Code:Satisfactory=S Not satisfactory=NS Not examined =NE				Oral polio/IPV		
Nose	Throat			Measles		
Teeth	Heart			Mumps		
Lungs	Abdomen			Rubella		
Genitalia	Hernia			Hib		
Skin	Musculoskeletal			Hep B		
General physical and emotional status				Tuberculin test	Year last given	Result
Urinalysis*	HGB*			Other		
Other notes  Physician's comments and recommendations. Give details or indicate management or significant illnesses.				Typhoid and Paratyphoid		
				Cholera		
				Yellow Fever		
				Rocky Mountain Spotted Fever		
				Typhus		
				This person is in satisfactory condition and may engage in all usual activities except as noted.		
				Licensed physicians signature:		
				Address		
				City	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 specific 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 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (parent/guardian)