



**GIRL HEALTH EXAMINATION RECORD**

This Side to be Filled in by the Parent and Reviewed with the Physician at the Time of Examination

Name ( Last, First, Initial )	Parent / Guardian				Phone ( )	
Address	City/ Town	State	Zip	Date of Birth	Age	Sex
In Case of Emergency- Notify	Address				Phone ( )	

Health History: (Check those that apply)

**Diseases**

- Chicken Pox
- Measles
- German Measles
- Mumps

**Allergies**

- Animals
- Food
- Hay Fever
- Insect Strings
- Medicine/Drugs
- Plants
- Pollen
- Others

**Chronic or Recurring Illness**

- Ear Infections
- Heart Defect/Disease
- Seizures
- Bleeding Disorders
- Asthma
- Hypertension
- Diabetes
- Musculoskeletal Disorder
- Other (Specify) \_\_\_\_\_

**Please describe condition and give dates:**

Operations or serious injuries \_\_\_\_\_  
 Other diseases/disabilities \_\_\_\_\_

**Comments where Applicable:**

Fainting \_\_\_\_\_ Sleep Disturbances \_\_\_\_\_  
 Bed Wetting \_\_\_\_\_ Menstrual Cramps \_\_\_\_\_  
 Constipation \_\_\_\_\_ Nosebleeds \_\_\_\_\_  
 Specific Activities to be Encouraged \_\_\_\_\_ Restricted \_\_\_\_\_  
 Special medical or dietary regimen to be followed (specify) \_\_\_\_\_

**This health history is correct and my daughter has permission to engage in all prescribed activities, except as noted by me and the examining Physician.**

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**Health Examination:** Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Record of Immunization:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_

Immunization	Year Primary Series Completed	Year of last Booster
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Appearance - Nutrition \_\_\_\_\_

D.P.T	_____	_____
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Without Glasses                      With Glasses  
 Eyes R 20/ \_\_\_\_ L 20/ \_\_\_\_      R 20/ \_\_\_\_ L 20/ \_\_\_\_

Diphtheria	_____	_____
Pertussis (Whooping Cough)	_____	_____
Tetanus	_____	_____

Ears \_\_\_\_\_ Hearing R \_\_\_\_\_ L \_\_\_\_\_

Td	_____	_____
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**Code:** Satisfactory (✓)  
 Not Satisfactory (x)  
 Not Examined (o)

Oral Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____

Nose \_\_\_\_\_ Throat \_\_\_\_\_

Hbpv	_____	_____
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Teeth \_\_\_\_\_ Heart \_\_\_\_\_

Tuberculin Test Type	Yr last given _____	Result _____
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Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_

Other \_\_\_\_\_

Genitalia \_\_\_\_\_ Hernia \_\_\_\_\_

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

Skin \_\_\_\_\_ Musculoskeletal \_\_\_\_\_

Licensed physician's name \_\_\_\_\_

General physical and emotional status \_\_\_\_\_

Licensed physician's Signature \_\_\_\_\_

Urinalysis\* \_\_\_\_\_ HBG\* \_\_\_\_\_

Address \_\_\_\_\_

Physician's comments and recommendation: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Date: \_\_\_\_\_

\*Not required for every health examination. Cadette/Senior/ Ambassador Girl Scout should have this test if she has not had it since puberty.