

GIRL SCOUTS OF SAN FRANCISCO BAY AREA
GIRL HEALTH EXAMINATION RECORD

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

Name (Last, First, Initial)		Birth Date		Grade
Address		City/Town	State	Zip
				Phone ()
Parent/Guardian's (1) Name		E-Mail Address (For GSSFBA use only)		Home Phone ()
Place of work		Title		Work Phone ()
Parent/Guardian's (2) Name		E-Mail Address (For GSSFBA use only)		Home Phone ()
Place of work		Title		Work Phone ()
Name of Alternate Emergency Contact If Parent/Guardian are Unavailable			Relationship	Home Phone ()
Address		City/Town	State	Zip
				Work Phone ()
INSURANCE INFORMATION, PLEASE COMPLETE THE FOLLOWING:				
Carrier		ID Number		Group Number
Member Services Phone Number ()		Address		City/Town State Zip

HEALTH HISTORY: (Check those that apply)

DISEASES: <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"/> Kidneys	ALLERGIES: <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 (specify): _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	CHRONIC or RECURRING ILLNESS: <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 Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other (specify): _____	APPLIANCES: <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Orthopedic Braces <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Dental Braces <input type="checkbox"/> Retainer <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	SUGGESTIONS FROM PARENT/GUARDIAN: 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
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DETAILS OF ANY CHECKED ITEMS ABOVE (i.e. allergic reactions to bee stings, food, or medications/drugs): _____

PLEASE DESCRIBE CONDITIONS AND GIVE DATES:

Operations or serious injuries: _____

Hospitalizations: _____

List any other diseases or disabilities: _____

Fainting _____	Sleep Disturbances _____
Bed Wetting _____	Menstrual Cramps _____
Constipation _____	Nosebleeds _____
Emotional Disturbances _____	Other (Specific) _____
Specific Activities to be Encouraged _____	Restricted _____

Any known recent exposure to contagious disease(s) within the last 6 weeks? YES NO **If YES, give details:** _____

Have you talked to your girl about menstruation? YES NO **Has she started menstruating?** YES NO

Is your child currently under care of physician? YES NO **If YES, give details:** _____

Special medical or dietary regimen to be followed (specify): _____

PARENT CONSENT: *This Girl Health Examination Record is complete and accurate to my knowledge. My daughter has permission to engage in all prescribed activities, except as noted by me and by the examining physician. I give permission for her to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood that every effort will be made to contact me or the person(s) noted above before taking this action.*

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

