

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:** _____

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. _____ Appearance-Nutrition _____ Without Glasses: With Glasses: Eyes R 20/____ L 20/____ R 20/____ L 20/____ Ears _____ Hearing R _____ L _____	<table style="width:100%; border-collapse: collapse;"> <thead> <tr style="background-color: #cccccc;"> <th style="width:50%; text-align: left;">Immunization</th> <th style="width:25%; text-align: left;">Year Primary Series Completed</th> <th style="width:25%; text-align: left;">Year of Last Booster</th> </tr> </thead> <tbody> <tr> <td colspan="3">DTaP</td> </tr> <tr> <td style="padding-left: 20px;">Diphtheria</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="padding-left: 20px;">Pertussis (Whooping Cough)</td> <td>_____</td> <td>_____</td> </tr> <tr> <td style="padding-left: 20px;">Tetanus (within last 10 years)</td> <td>_____</td> <td>_____</td> </tr> <tr> <td colspan="3">Td</td> </tr> <tr> <td>Oral Polio/IPV</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Measles</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Mumps</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Rubella</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Hib</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Hep B</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Tuberculin Test</td> <td>Year last given _____</td> <td>Result _____</td> </tr> <tr> <td>Typhoid and Paratyphoid</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Cholera</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Yellow Fever</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Typhus</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Rocky Mountain Spotted Fever</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Other: (specify) _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	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 Mountain Spotted Fever	_____	_____	Other: (specify) _____	_____	_____
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Nose _____ Throat _____ Teeth _____ Heart _____ Lungs _____ Abdomen _____ Genitalia _____ Hernia _____ Skin _____ Musculoskeletal _____ General physical and emotional status _____ Urinalysis* _____ HGB* _____ Other notes _____ Physician's comments and recommendations. Give details or indicate management or significant illnesses. _____ _____ _____ _____ *Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty.	<p>This person is in satisfactory condition and may engage in all usual activities except as noted.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%; border-bottom: 1px solid black;">(Print) Licensed Physician's Name</td> <td style="width:30%; border-bottom: 1px solid black;">Licensed Physician's Signature</td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black;">Address/City/State/Zip</td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black;">E-Mail</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Area Code + Phone ()</td> <td style="border-bottom: 1px solid black;">FAX: Area Code + Phone ()</td> <td style="border-bottom: 1px solid black;">Date</td> </tr> </table>		(Print) Licensed Physician's Name	Licensed Physician's Signature	Address/City/State/Zip		E-Mail		Area Code + Phone ()	FAX: Area Code + Phone ()	Date																																															
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Is your girl/ward disabled? NO YES If YES, does she need accommodation? NO YES If YES, attach a separate paper to explain.

MEDICATIONS: Medication cannot be administered that is not in its original bottle, labeled with the child's own name, accompanied by specific written dispensing instructions by parent/guardian or physician. Medications include, but are not limited to: prescription, over the counter, vitamins, herbal and homeopathic remedies.

IMPORTANT: 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 Girl Health Examination Record 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 OF PARENT/GUARDIAN: _____ **DATE:** _____ 555x