Girl Scouts of Northern Illinois
Medical Examination Form for Adults
Participating in International Travel

(This section is to be completed by a physician after the review of health history. Adult must complete all the information in the Health History to the best of their knowledge and sign before meeting with licensed professional.)

Medical Examination: A medical examination is completed for trips lasting more than three nights. The examination is completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months unless a health issue is present.

Medical Examination

Height: _____ Weight: _____ Pulse Rate: _____ B. P.: _____/_____
Sugar: _____ Albumin: _____ Blood Hemoglobin: _____
Hearing: R ___ L ___ Eyes: With Glasses R 20/____ L 20/____ Without Glasses R 20/____ L 20/____
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

_____ Nose	_____ Abdomen	_____ Urinalysis*	Other: _____
_____ Throat	_____ Hernia	_____ HGB*	_____
_____ Teeth	_____ Genitalia	_____ Appearance/Nutrition	_____
_____ Heart	_____ Skin	_____ General Physical State	_____
_____ Lungs	_____ Musculoskeletal	_____ General Emotional State	_____

*Girls should have this test if she had not had it since entering puberty.

Does this applicant have any conditions which might limit activity for this event/travel/assignment; such as chronic disease, weight or limit participation in swimming or other strenuous activity? Yes No

If yes, please explain: _____

_____

Record of Immunization

	Date Series was Completed	Year of Last Booster
Hep B	_____	_____
DTap/Tdap	_____	_____
DT/Td	_____	_____
Hib	_____	_____
IPV/OPV	_____	_____
PCV7	_____	_____
MMR	_____	_____
Varicella	_____	_____
Other:		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

	Date Series was Completed	Year of Last Booster
Typhoid	_____	_____
Paratyphoid	_____	_____
Cholera	_____	_____
Yellow Fever	_____	_____
Typhus	_____	_____
Rocky Mountain Spotted Fever	_____	_____
Tuberculin Test: Year last given	_____	Result _____
Not required immunizations, but recommended		
HPV	_____	_____
Rota	_____	_____
MCV4/MPSV4	_____	_____
Hep A	_____	_____
TIV/LAIV	_____	_____

Physician Information

Licensed Physician Name: (Last, First, Middle Initial)	**Phone Number:**		
Address:	**City:**	**St:**	**Zip:**

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

Signature of Licensed Physician: _____ **State License Number:** _____ **Date:** _____

HEALTH INFORMATION PRIVACY STATEMENT

The **Medical Examination Form** 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 for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years in the case of treatment. 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 and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Adult Medical Examination Form is complete and accurate.

Signature of Adult Participant: _____ **Date:** _____