

# GIRL HEALTH HISTORY

Participant's Name: \_\_\_\_\_ Date of Birth (mm/dd/yy): \_\_\_\_\_  
 LAST FIRST MI  
 Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Guardian Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Please check all that apply:

<b>Diseases</b>	<b>Chronic/Reoccurring Illness</b>	
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Musculoskeletal Disorders
<input type="checkbox"/> Measles	<input type="checkbox"/> Heart Defect/Disease	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> German Measles	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Mumps	<input type="checkbox"/> Bleeding Disorders	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Kidney	<input type="checkbox"/> Diabetes	

Please list all allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please describe conditions and give dates:  
**Operations or serious injuries:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_  
 \_\_\_\_\_

**Other diseases:** \_\_\_\_\_  
 \_\_\_\_\_

**Disabilities:** \_\_\_\_\_

Check if applicable:

<input type="checkbox"/> Occasional Bedwetting	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Constipation
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Menstrual Cramps
<input type="checkbox"/> Emotional Disturbances	<input type="checkbox"/> Other _____	

**INSURANCE INFORMATION (PLEASE PRINT)**

**Carrier:** \_\_\_\_\_

**ID Number** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Member Services Phone:** \_\_\_\_\_

**My child has permission to take the following over the counter medications according to package instructions, which I have supplied in original containers:**

Tylenol/Acetaminophen  
 Advil/Ibuprofen  
 Sudafed/Decongestant  
 Benadryl/Antihistamine  
 Pepto-Bismol  
 Tums/Antacids  
 Robitussin/Expectorant

Guardian Signature \_\_\_\_\_  
 Date \_\_\_\_\_

**CURRENT PHYSICIAN INFORMATION:**

**Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

<b>MEDICATIONS:</b>			
Name of Medication	Purpose	Dosage	At What Time

ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINER MARKED WITH PARTICIPANT'S NAME If more medications, attach another page

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted.

**Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HEALTH INFORMATION PRIVACY STATEMENT:** *The Girl Health History record is for health care concerns. All records will be handled by staff whose job includes processing this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor and only minimal necessary information may be shared with staff in order to provide safety and health care. Girl Scouts of Northern Illinois will retain the health form until destroyed. All forms/records with noted treatment will be retained for seven years past the age of maturity of the participant. Access will be limited, but the participant or their legal representative may request copies. 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.*

**Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# GIRL HEALTH EXAMINATION RECORD

**This side is to be filled out by a physician after review of health history with guardian.**

Date of Examination: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

B.P. \_\_\_\_\_ Appearance-Nutrition \_\_\_\_\_

Without glasses \_\_\_\_\_ with glasses \_\_\_\_\_

Eyes: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Ears: \_\_\_\_\_

Hearing: R \_\_\_\_\_ L \_\_\_\_\_

**CODE:                      SATISFACTORY=S                      NOT SASIFACTORY=NS                      NOT EXAMINED=NE**

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

Teeth \_\_\_\_\_ Heat \_\_\_\_\_

Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_

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

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

General Physical and emotional status \_\_\_\_\_

Urinanalysis\* \_\_\_\_\_ HGB \_\_\_\_\_

Other notes \_\_\_\_\_

\*Not required for every health examination. A Girl Scout Daisy, Brownie or Junior should have this test if she has not already had it, either when entering school or at anytime since. A Girl Scout Cadette or Senior should have this test if she has not had it since entering puberty.

\*\*Adult tetanus-diphtheria toxoid

\*\*\*Haemophilus b polysaccharide vaccine

## RECORD OF IMMUNIZATIONS:

Immunization	Year Primary Series Completed	Year of Last Booster
D.T.P	_____	_____
Diphtheria	_____	_____
Pertussis (whooping cough)	_____	_____
Tetanus	_____	_____
Td**	_____	_____
Oral polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hbpv***	_____	_____
Tuberculin test	Type _____	_____
	Year last given _____	_____
	Result _____	_____
Other	_____	_____

Physician's comments and recommendations

Give details or indicate management of significant illnesses.

Any special medical or dietary regimen to be followed? Specify: \_\_\_\_\_

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

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

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

Licensed Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_