



Girl Scouts of Northern Illinois Medical Examination Form for Minors For International Travel

(This section is to be completed by a physician after the review of health history with parent/guardian. Parent/Guardian must complete all the information of 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 – Must be completed in detail.

Height: _____	Weight: _____	B. P.: _____/_____	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.

Record of Immunization – Must be completed in detail.

	Date Series was Completed	Year of Last Booster		Date Series was Completed	Year of Last Booster
Hep B	_____	_____	Typhoid	_____	_____
DTap/Tdap	_____	_____	Paratyphoid	_____	_____
DT/Td	_____	_____	Cholera	_____	_____
Hib	_____	_____	Yellow Fever	_____	_____
IPV/OPV	_____	_____	Typhus	_____	_____
PCV7	_____	_____	Rocky Mountain	_____	_____
MMR	_____	_____	Spotted Fever	_____	_____
Varicella	_____	_____	Tuberculin Test: Year last given	_____	Result _____
Other:			Not required immunizations, but recommended		
_____	_____	_____	HPV	_____	_____
_____	_____	_____	Rota	_____	_____
_____	_____	_____	MCV4/MPSV4	_____	_____
_____	_____	_____	Hep A	_____	_____
_____	_____	_____	TIV/LAIV	_____	_____

Personal and religious beliefs dictate against immunizations: Yes No

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 for Minors** 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 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 and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Health History and Medical Examination Form for Minors is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.

Signature of Parent/Guardian: _____

Date: _____