



GIRL HEALTH EXAMINATION RECORD

Trip Type: Council Sponsored Troop

Destination _____ Date _____

This part to be filled in by adult and reviewed with physician at the time of examination				
Name (Last, First, Initial)			Sex	Birth
Address			City or Town	State
			Zip	Phone
				()
In Emergency Notify	Address		Relationship	
			Phone	
			()	

INSURANCE INFORMATION, PLEASE COMPLETE THE FOLLOWING:

Carrier	ID Number	Group Number
Member Services Phone Number	Address	
()		

HEALTH HISTORY: (check if you have had any of the following)

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"/> Kidney	ALLERGIES <input type="checkbox"/> Animals _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Hay Fever _____ <input type="checkbox"/> Insect Bites/Stings _____ <input type="checkbox"/> Medicine/Drugs _____ <input type="checkbox"/> Pollen _____ <input type="checkbox"/> Other (specify) _____	<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	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"/> Tums/antacid <input type="checkbox"/> Robitussin/expectorant <input type="checkbox"/> Calamine lotion <input type="checkbox"/> Cough drops
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Please describe conditions and give dates:

Operations or serious injuries: _____
 Hospitalizations: _____
 Other Diseases/disabilities: _____

Comments where applicable:

Fainting _____ Sleeping Disturbances _____
 Bedwetting _____ Menstrual Cramps _____
 Constipation _____ Nosebleeds _____
 Emotional Disturbances _____ Other _____
 Specific activities to be encouraged _____ Restricted _____
 Special medical or dietary regimen to be followed (specify) _____

PLEASE LIST BELOW ANY CURRENT MEDICATIONS BEING TAKEN – 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. 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. I authorize emergency medical treatment be given if needed for illness or injury.

This health history is complete and accurate. I give permission to engage in all prescribed activities, except as noted.

SIGNATURE: _____ DATE: _____
 (Participant)

This form is valid for 24 months. Please keep a copy for your records.

