Girl Scout Council of the Florida Panhandle, Inc.

Tallahassee Service Center ♦ 250 Pinewood Drive ♦ Tallahassee, FL 32303-4838

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Girl Health Record

GIRL HEALTH EXAMINATION RECORD

This part to be filled in by parent and reviewed with physician at the time of examination

Name (Last, First, Initial)		Parent or Guardian				Phone	
						( )	
Address	City or Town		State	Zip	Birth	Age	Sex
In Emergency Notify		Address				Phone	
						( )	

Insurance Information, please complete the following:

Carrier	ID Number	Group Number
Member Services Phone Number	Address	

Health History: (Check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions From Parent:
❑ Chicken Pox	❑ Animals ____________	❑ Ear Infections	My daughter has permission to take or use the following:
❑ Measles	❑ Food ____________	❑ Heart Defect/Disease	{ } Tylenol/Acetaminophen
❑ German Measles	❑ Hay Fever ____________	❑ Seizures	{ }Advil/Ibuprofen
❑ Mumps	❑ Insect Stings ________	❑ Bleeding Disorders	{ }Sudafed/decongestant
❑ Rheumatic Fever	❑ Medicine/Drugs ______	❑ Asthma	{ }Benadryl/antihistamine
❑ Tuberculosis	❑ Plants ____________	❑ Hypertension	{ }Pepto Bismol
❑ Kidney	❑ Pollen ____________	❑ Diabetes	{ } Tums/antacid
	❑ Other (specify) ________	❑ Musculoskeletal Disorders	{ }Robitussin/expectorant
		❑ Arthritis	{ }Swimmers' Ear/alcohol-vinegar solution
		❑ Sinusitis	
		❑ Other_________	

Please describe conditions and give dates:

Operations or serious injuries:____

Hospitalizations: ____

Other diseases/disabilities: ____

Comments where applicable:

Fainting_______________________________ Sleep disturbances ____________________

Bed wetting ____________________________ Menstrual cramps ____________________

Constipation ___________________________ Nosebleeds ___________________________

Emotional disturbances __________________ Other ________________________________

Specific activities to be encouraged __________ Restricted____________________________

Special medical or dietary regimen to be followed (specify)__________________________

This health history 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** ____________________

Girl Health Record

Name: ______________________________ Date: ________________

(This part to be filled in by physician after review of health history with parent/guardian.)

Health Examination:

Height __________ Weight________ B.P. ________

Appearance-Nutrition______________________

	Without Glasses		With Glasses	
Eyes	R 20/ _____	L 20/ _____	R 20/ ____	L 20/ _____

Ears_____________ Hearing R ______ L _________

Code: Satisfactory =S | Not satisfactory = NS | Not examined = NE

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.

Record of Immunization:

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	Yr. last given___	Result_________
Other	____________	____________
Typhoid and Paratyphoid	____________	____________
Cholera	____________	____________
Yellow Fever	____________	____________
Typhus	____________	____________
Rocky Mountain Spotted Fever	____________	____________

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

Licensed physician's name:

____

Licensed physician's signature:

____

Address _________________________

City ____________ State___________ Zip _______

Phone(______) ____________ Date ____________

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 health form 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: ______________________________________DATE: __________________

(Parent/guardian)