

Adult Girl

Health History Record

NAME OF PARTICIPANT		DATE OF BIRTH	SEX	AGE	TROOP/GROUP NO.	PARENT/GUARDIAN NAME(S)	
ADDRESS						PHONE: (AREA CODE) DAY	(AREA CODE) EVENING
CITY	STATE	ZIP	PHONE: (AREA CODE) DAY	(AREA CODE) EVENING	IN EMERGENCY NOTIFY: NAME		RELATIONSHIP
FAMILY MEDICAL/HOSPITAL INSURANCE CARRIER:		FAMILY PHYSICIAN NAME:		POLICY OR GROUP NO.		PHONE: (AREA CODE) DAY	(AREA CODE) EVENING

part 1: CHECK THOSE THAT APPLY AND GIVE DATES

part 2: Other Conditions:

- DISEASES:**
- CHICKEN POX _____
 - MEASLES _____
 - GERMAN MEASLES _____
 - MUMPS _____
 - OTHER (SPECIFY) _____

- ALLERGIES:**
- ANIMALS _____
 - FOOD _____
 - HAY FEVER _____
 - INSECT STINGS _____
 - MEDICINE/DRUGS _____
 - PLANTS _____
 - POLLEN _____
 - OTHER (SPECIFY) _____

- CHRONIC OR RECURRING ILLNESS:**
- EAR INFECTIONS _____
 - HEART DEFECT /DISEASE _____
 - SEIZURES _____
 - BLEEDING/CLOTTING DISORDERS _____
 - ASTHMA _____
 - HYPERTENSION _____
 - DIABETES _____
 - MUSCULOSKELETAL DISORDERS _____
 - OTHER (SPECIFY) _____

- BED WETTING
- CONSTIPATION
- MENSTRUAL CRAMPS
- MOTION SICKNESS
- NOSEBLEEDS
- SLEEP DISTURBANCE
- EMOTIONAL DISTURBANCES
- FAINTING
- HEARING IMPAIRMENT
- SICKLE CELL TRAIT OR DISEASE
- SPECIAL DIETARY REGIMEN
- WEARS GLASSES OR CONTACT LENSES
- OTHER (SPECIFY) _____

PLEASE EXPLAIN ANY ITEMS THAT ARE CHECKED.

INDICATE ANY INFORMATION USEFUL TO THE ADULT IN CHARGE IN RELATION TO ANY OF THESE HEALTH CONDITIONS.

SPECIFIC ACTIVITIES TO BE ENCOURAGED OR RESTRICTED

DATE OF LAST HEALTH EXAMINATION? _____

ANY COMPLICATING MEDICAL PROBLEMS NOTED IN LAST HEALTH EXAMINATION? _____

SINCE LAST EXAM HAS PARTICIPANT HAD:

OPERATIONS OR SERIOUS INJURIES REQUIRING MEDICAL ATTENTION? _____

HOSPITALIZATIONS OR EMERGENCY ROOM VISITS? _____

AN ILLNESS LASTING MORE THAN FIVE DAYS? _____

EXPOSURE TO A CONTAGIOUS DISEASE? _____

IS PARTICIPANT CURRENTLY UNDER THE CARE OF A PHYSICIAN OR PSYCHOLOGIST? _____

USING PRESCRIBED OR OVER-THE-COUNTER MEDICATIONS? _____

HAD ANY RESTRICTIONS CONCERNING PHYSICAL ACTIVITIES? _____

PLEASE DESCRIBE CONDITIONS AND GIVE DATES TO ANY "YES" ANSWERS:

This health history is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me and the examining physician. In case of illness or injury, I/we give permission for her/him to receive first aid, and to receive emergency treatment from a licensed physician. It is understood that all reasonable efforts would be made to contact the parent or guardian. I/we further release Columbia River Girl Scout Council, Inc. from any liability or damages, including any claim for injuries incurred by my/our child as a result of participation in this Girl Scout activity.

SIGNATURE OF PARENT(S)/GUARDIAN _____ / _____ DATE _____

This health history is complete and accurate. I am able to engage in all prescribed activities except as noted.

SIGNATURE OF ADULT _____ DATE _____

Form # 204 • ZIP: JAL.FORMS • 7/04

Phone area code () _____

City _____

State _____ Zip _____

Address _____

Licensed Physician's name _____

Licensed Physician's signature _____ Date _____

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

Give details or indicate management of significant illnesses.

Physician's comments and recommendations

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

Other notes: _____

Urinalysis* _____ HGB.* _____

General Physical _____

Musculoskeletal _____

Skin _____

Hernia _____

Genitalia _____

Abdomen _____

Lungs _____

Heart _____

Teeth _____

Throat _____

Nose _____

Code: = Satisfactory X = Not Satisfactory O = Not Examined

Immunization _____ Year Primary Series was Completed _____ Year of Last Booster _____

D.T.P. _____

Diphtheria _____

Pertussis (Whooping Cough) _____

Tetanus _____

Td** _____

Oral polio _____

Measles _____

Mumps _____

Rubella _____

Hib** _____

Hep B _____

Tuberculin test: _____ Year last given _____

Other _____ Result _____

**Adult tetanus-diphtheria toxoid

***Haemophilus influenza b

Record of Immunization

Date of Exam _____

Height _____

Weight _____

B.P. _____

Appearance—Nutrition _____

Eyes (without glasses) R 20/ _____ L 20/ _____

(with glasses) R 20/ _____ L 20/ _____

Color Vision _____

Ears—Hearing _____ R _____ L _____

Health Examination: This side to be completed by Physician.