



Girl Scouts - Joshua Tree Council
HEALTH HISTORY AND EXAMINATION RECORD

This part is to be filled out by parent/guardian of minors or by adult members themselves. Please print.

Name _____ Birthdate ____/____/____ Sex _____ Age _____
Last First Initial

Parent or Guardian (or Spouse) _____

Home address _____ City _____ State _____ Zip _____ Phone (____) _____

Business address _____ City _____ State _____ Zip _____ Phone (____) _____

Second Parent or Guardian for Emergency Contact _____ Relationship _____

Home address _____ City _____ State _____ Zip _____ Phone (____) _____

Business address _____ City _____ State _____ Zip _____ Phone (____) _____

If not available in an emergency, notify: _____ Relationship _____

Home address _____ City _____ State _____ Zip _____ Phone (____) _____

Name of Dentist/Orthodontist _____ Phone (____) _____

Name of Family Physician _____ Phone (____) _____

Do you carry family medical/hospital insurance? Yes No Carrier name _____ Policy/Group # _____

Carrier address _____ City _____ State _____ Zip _____ Phone (____) _____

Health History: Check (Give approximate dates)		Allergies (Dates no needed)	
<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Poison Oak/Ivy
<input type="checkbox"/> Heart Defect/Disease	<input type="checkbox"/> Emotional Disturbances	<input type="checkbox"/> Asthma	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Fainting	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Animals
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Other medications	<input type="checkbox"/> Foods
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Constipation	_____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Nose Bleed	_____	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	_____	_____

Operations or serious injuries (dates) _____

Chronic or recurrent illness or medical conditions _____

Other diseases/disabilities _____

Current medications (send with instructions) _____

Dietary restrictions _____

For female – menstruation Yes No If yes, normal? Yes No If no, does she know about it? Yes No

Explanation of health history or allergies and/or health care information _____

This health history is complete and accurate. The person herein described has permission to engage in all activities except as noted by me or the examining physician.

AUTHORIZATION FOR TREATMENT: I hereby consent to an emergency x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care for me or my daughter under the supervision of and as deemed advisable by a physician licensed under the Medical Practice Act. It is understood that this authority is given in advance of the need for any diagnosis, treatment or hospital care but is to provide authority pursuant to Section 6910 of the California Family Code.

Girl's name _____ Signature of Parent/Guardian or Adult member _____ Date _____

If for religious reasons you cannot authorize medical treatment, then a legal waiver must be signed for attendance.

PLEASE NOTE: This Health History and Examination Record is valid for 24 MONTHS from the date of the physical examination. KEEP THE ORIGINAL AND SUBMIT A PHOTOCOPY (BOTH SIDES) to each Girl Scout activity which requires a health form.

Immunization History: Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Please use this space to update this form if the health examination was completed more than six months ago.

Vaccines	Immunizations	Booster
Diphtheria Pertussis (Whooping cough) DPT Tetanus or	1. 2. 3.	1. 2.
Tetanus Diphtheria or TD		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (Hard Measles, Red Measles, Rubeola)		
Mumps		
Rubella (German Measles, 3-day Measles)		
Other		
Tuberculin Test given _____ (most given)		
Hemophilus Influenza B (HIB)		
Hepatitis B		

Injuries/operations

Illness

Changes in medication(s)

Other

No changes

Signature of parent/guardian

Date

TO BE FILLED OUT BY LICENSED PHYSICIAN

I have examined the applicant within the past two years. Date examined _____
 Height _____ Weight _____ Blood Pressure _____ Pulse _____

Examination finding – check if condition is satisfactory. If not satisfactory, explain in space provided below.

- | | | | |
|---|---------------------------------|----------------------------------|--|
| <input type="checkbox"/> Eye and Vision | <input type="checkbox"/> Throat | <input type="checkbox"/> Heart | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Ears and Hearing | <input type="checkbox"/> Teeth | <input type="checkbox"/> Lungs | <input type="checkbox"/> Genitalia |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Skin | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Menstrual Periods |

General physical and emotional status _____

The applicant is under the care of a physician for the following condition(s) _____

Current treatment (list all current medication(s)) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? Yes No Does applicant have diabetes? Yes No

Does applicant have allergies? (Please list all known allergies) _____

Does applicant have any condition(s) which might limit participation in strenuous activities? Yes No

Any treatment to be continued at camp/event? _____

Any medically prescribed meal plan or dietary restrictions at camp/event? _____

Activities to be encouraged or limited at camp/event? _____

Additional health information or recommendations _____

Licensed Physicians Name (please print) _____	Phone (____) _____
Address _____	City _____ State _____ Zip _____
Licensed Physicians Signature _____	Date _____

Information on this form is not part of any acceptance process, but is gathered to assist in identifying appropriate care.