

GIRL HEALTH RECORD - HEALTH EXAMINATION AND IMMUNIZATION

➤ To be filled in by physician after review of health history with parent/guardian.
➤ This form must be completed within the 24 months preceding a girl's participation in a trip of three or more nights or in contact sports on an organized competitive basis.

Give completed form to Troop Leader or Event Facilitator/Coordinator for trip of three or more nights. Give to school or sports organization as required.

Girl Name (Last, First, Initial)			Date		
Health Examination (This part is to be filled in by physician after review of health history with parent /guardian.)					
Date of Exam (MUST HAVE BEEN GIVEN WITHIN LAST 24 MONTHS BEFORE THE EVENT):					
Height	Weight	Blood Pressure			
Appearance-Nutrition					
Eyes: Without Glasses	Left: 20/___	Right: 20/___	With Glasses	Left: 20/___	Right: 20/___
Color Vision:			Other Notes:		
Ears: Hearing: Right:		Left:			
Code: Satisfactory: <input type="checkbox"/> Not Satisfactory: <input checked="" type="checkbox"/> Not Examined: <input type="checkbox"/>					
Nose	Genitalia		General Physical and Emotional Status:		
Throat	Hernia				
Teeth	Skin				
Heart	Musculoskeletal				
Lungs	Urinalysis*				
Abdomen	HGB*				
* Not required for every health examination. A girl 11-18 should have this test if she has not had it since entering puberty.					
Record of Immunizations					
Immunization	Year Primary Series Completed	Year of Last Booster	Immunization	Year Primary Series Completed	Year of Last Booster
DTaP			Hib**		
Diphtheria			Typhoid and Paratyphoid		
Pertussis (Whooping Cough)			Rubella		
Tetanus			Cholera		
Hep B			Yellow Fever		
Oral Polio			Typhus		
Measles			Rocky Mountain Spotted Fever		
Mumps			Other		
Tuberculin test - year last given:		Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		**Haemophilus influenza b	
To a Girl Scout volunteer present and certified in First Aid/CPR, I give permission to administer the medication marked below, according to the package directions or Physician's Standing Orders.					
<input type="checkbox"/> Tylenol/acetaminophen		<input type="checkbox"/> Antibiotic Ointment/Bacitracin/Bactoban		<input type="checkbox"/> Hydrocortisone Cream	
<input type="checkbox"/> Ibuprofen		<input type="checkbox"/> Benadryl/antihistamine		<input type="checkbox"/> Epinephrine	
<input type="checkbox"/> Antacids		<input type="checkbox"/> Antidiarrhea/Pepto-Bismol		<input type="checkbox"/> Epi-Pen Jr. (up to 9 years of age)	
<input type="checkbox"/> Calamine/Caladryl		<input type="checkbox"/> Robitussin/expectorant		<input type="checkbox"/> Epi-Pen (over 9 years of age)	
<input type="checkbox"/> Wound Wash and/or Hydrogen Peroxide		<input type="checkbox"/> Swimmer's Ear/alcohol-vinegar solution			
Physician's comments and recommendations. Give details or indicate management of significant illness.					
This person is in satisfactory condition and may engage in all usual activities, except as noted.					
Licensed physician's name			Licensed physician's signature		
City		ST		Zip Code	
Phone _____			Date _____		

IF OVER-THE COUNTER OR PRESCRIPTION MEDICATIONS MAY BE TAKEN **FOR AN UPCOMING TRIP OF MORE THAN THREE NIGHTS**, PLEASE COMPLETE, SIGN, AND ATTACH THE **MEDICATION ADMINISTRATION AUTHORIZATION** FORM. INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g., food, medications, environmental).