girl scouts of west central florida

Girl Scouts of West Central Florida
Health Examination Form
For Girls and Adults

This Health Examination Form should be carried with the troop/group at all times**.** (See *Volunteer Essentials* and *Safety Activity Checkpoints*, as indicated under each activity for information about health examinations).

Please Print

Name: _____ Birth Date: _____ Age: _____ Troop#: _____

Name of Parent/Guardian (or spouse): _____

Home Address: _____City: _____ Zip:_____

Business Address: _____ City: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

If not available in an emergency, notify:

1. Name: _____ Phone: _____Address: _____
2. Name: _____ Phone: _____ Address: _____

Health History: (Give approximate dates)

Disorders		**Allergies**		**Diseases**	
Frequent ear infections	_____	Animals	_____	Chicken Pox	_____
Heart defect/disease	_____	Hay fever	_____	Measles	_____
Seizures	_____	Ivy poisoning, etc.	_____	German Measles	_____
Diabetes	_____	Penicillin	_____	Mumps	_____
Bleeding/clotting disorders	_____	Asthma	_____		
Musculoskeletal disorders	_____	Insects	_____		

Other drugs including over the counter medications: _____

Other: _____

Operations or serious injuries (dates): _____

Chronic or recurring illness: _____

Special Dietary needs: _____

Current medications: _____

Is parent sending medications: _____ Yes _____ No

Other diseases or details of above: _____

Is participant currently under the care of a physician or psychologist? _____ Yes _____ No

Name of family physician/psychologist:_____ Phone #: _____

Name of dentist/orthodontist:_____ Phone #: _____

Do you carry family medical/hospital insurance?_____ If yes, indicate Carrier: _____

Policy or Group #: _____ (**NOTE: Your family insurance is primary coverage)**

Comments where Applicable:
Fainting: _____ Bed Wetting: _____ Sleep Disturbances: _____
Constipation: _____ Glasses/Contacts: _____ Hearing Impairment: _____
Emotional Disturbances: _____ Other: _____

Immunization History
Please record the date (month and year) of basic immunizations and most recent booster doses:

Vaccines	Date of Basic Immunization	Date of Last Booster
Diphtheria	1. _____	1. _____
Pertussis (Whooping Cough)	2. _____	2. _____
Tetanus	3. _____	3. _____
DPT	4. _____	4. _____
Oral Polio (Sabin)	5. _____	5. _____
Injectable Polio (Salk)	6. _____	6. _____
Measles(hard measles, red measles)	_____	
Mumps	_____	
Rubella (German measles, 3 day measles)	_____	
Other:	_____	

Tuberculin test given (most recent) _____ Result _____ Positive _____ Negative

Activities
May this child take part in swimming activities? _____ Yes _____ No
If yes, may ear drops (alcohol/vinegar solution) be administered after swimming? ☐ Yes ☐ No

Are there any specific activities that should be restricted? _____

My child will have her own sunscreen: _____ Yes _____ No
I understand that sunscreen will not be provided: _____ (initial)

Additional Comments:
_____
_____
_____

Important: The following section must be completed for participation.

This health history is correct so far as I know, and the person herein described has permission to engage in all activities except as noted by me.

Signature _____ Date: _____
Parent or Guardian

For specific activities requiring health examinations, please review *Volunteer Essentials* and *Safety Activity Checkpoints*, as indicated under each activity.

Signature _____ Date: _____
Person Administering Health Exam

_____
Title/Position