girl scouts of west central florida

Health History and Medical Examination Form

Camper Name: _____ **Date of Birth:** _____

A medical examination is required for overnight camps and must be completed and signed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 12 months (other physical/examination forms are excepted if exam was completed in the preceding 12 months and signed by the physician). Please call us if you have any questions.

Medical Examination – Must be completed in detail.

Height:	Weight:
Eyes: With Glasses R 20/	L 20/
Eyes: With Glasses R 20/	L 20/

Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

	Nose		Abdomen
	Throat		Hernia
	Teeth		Genitalia
	Heart		Skin
	Lungs		Musculoskeletal

B. P.:	
Hearing:	R L

	Appearance/Nutrition
	General Physical State
	General Emotional State
	Other:

Record of Immunization – Must be completed in detail:

Required Immunizations	Date Series Was Completed	Year of Last Booster
Hep B		
DTap/Tdap		
Hib		
IPV/OPV		
PCV7		
MMR		
Varicella		
Other:		

Recommended but not Required Immunizations	Date Series Was Completed	Year of Last Booster
HPV		
Rota		
MCV4/MPSV4		
Hep A		
TIV/LAIV		
COVID		
Other		

Personal and religious beliefs dictate against immunizations: Yes No

Allergies:

- ☐ Animals
- ☐ Food
- ☐ Carries EpiPen
- ☐ Knows how to self-administer EpiPen
- ☐ Permission to self-carry EpiPen
- ☐ History of anaphylaxis
- ☐ Medications
- ☐ Seasonal
- ☐ Takes allergy medication
- ☐ Other: _____

Special Dietary Needs:

- ☐ Egg allergy
- ☐ Gluten intolerant/celiac
- ☐ Lactose intolerant
- ☐ Peanut/ tree nut allergy
- ☐ Vegetarian
- ☐ Vegan
- ☐ Other: _____

girl scouts of west central florida

Health History and Medical Examination Form

Medical Conditions:

- ☐ Asthma
- ☐ Permission to self-carry and administer inhaler
- ☐ Bed Wetting
- ☐ Behavioral/ mental health concerns
- ☐ Bleeding/clotting disorders
- ☐ Diabetes
- ☐ Hearing impairment
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Fainting
- ☐ Learning/cognitive delay
- ☐ Musculoskeletal disorders
- ☐ Prior hospitalization
- ☐ Prior serious injury
- ☐ Prior surgery
- ☐ Seizures
- ☐ Sleep disturbances
- ☐ Speech impairment
- ☐ Visual impairment
- ☐ Other: _____

Please elaborate on any positive responses. Attach addendum if necessary:

_____

_____

_____

Provider Clearance

This camper is medically cleared for overnight camp (please circle one): Yes No

Physician Information

Licensed Physician Name: (Last, First, Middle Initial)	Phone Number:		
Address:	City:	St:	Zip:
This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.			

Signature of Licensed Physician:_____

State License Number:_____ **Date:** _____