GIRL HEALTH EXAMINATION RECORD

This part to be filled in by parent and reviewed with physician at the time of examination

Name (Last, First, Initial)	Parent or Guardian				Phone	
					( )	
Address	**City or Town**	**State**	**Zip**	**Birth**	**Age**	**Sex**
In Emergency Notify	**Address**				**Phone**	
					( )	

Insurance Information, please complete the following:

Carrier	ID Number	Group Number
Member Services Phone Number	**Address**	

Health History: (Check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions From Parent:
❑ **Chicken Pox** ❑ **Measles** ❑ **German Measles** ❑ **Mumps** ❑ **Rheumatic Fever** ❑ **Tuberculosis** ❑ **Kidney**	❑ **Animals** _____ ❑ **Food**_____ ❑ **Hay Fever**_____ ❑ **Insect Stings** _____ ❑ **Medicine/Drugs**_____ ❑ **Plants**_____ ❑ **Pollen**_____ ❑ **Other (specify)** _____	❑ **Ear Infections** ❑ **Heart Defect/Disease** ❑ **Seizures** ❑ **Bleeding Disorders** ❑ **Asthma** ❑ **Hypertension** ❑ **Diabetes** ❑ **Musculoskeletal Disorders** ❑ **Arthritis** ❑ **Sinusitis** ❑ **Other**_____	**My daughter has permission to take or use the following:** { }Tylenol/Acetaminophen { }Advil/Ibuprofen { }Sudafed/decongestant { }Benadryl/antihistamine { }Pepto Bismol { }Tums/antacid { }Robitussin/expectorant { }Swimmers' Ear/alcohol-vinegar solution

Please describe conditions and give dates:

Operations or serious injuries:_____

Hospitalizations: _____

Other diseases/disabilities: _____

Comments where applicable:

Fainting_____ Sleep disturbances_____

Bed wetting_____ Menstrual cramps_____

Constipation _____ Nosebleeds _____

Emotional disturbances _____ Other _____

Specific activities to be encouraged _____ Restricted _____

Special medical or dietary regimen to be followed (specify)

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.

_____ _____

Signature of Parent/Guardian **Date**

Name: _____ **Date:** _____ **(This part to be filled in by physician after review of health history with parent/guardian.)**

Health Examination:

Height _____ **Weight**_____**B.P.** _____
Appearance-Nutrition _____

	Without Glasses	With Glasses
Eyes	**R 20/**_____ **L 20/**_____	**R 20/**____ **L 20/** _____

Ears_____ **Hearing R** _____ **L**_____

Code: Satisfactory =S | Not satisfactory = NS | Not examined = NE

Nose _____ **Throat** _____
Teeth _____ **Heart** _____
Lungs _____ **Abdomen**_____
Genitalia _____ **Hernia** _____
Skin _____ **Musculoskeletal** _____
General physical and emotional status _____
Urinalysis* _____ **HGB*** _____
Other notes_____
_____
_____

Physician's comments and recommendations
Give details or indicate management or significant illnesses.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

***Not required for every health exam. A girl 11-18 should have this test if she has not had it since entering puberty.

Record of Immunization:

Immunization	Year Primary Series Completed	Year Of Last Booster
DTaP	_____	_____
Diphtheria		_____
Pertussis (Whooping Cough)		_____
Tetanus (within last 10 years)		_____
Td	_____	_____
Oral polio/IPV	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hib	_____	_____
Hep B	_____	_____
Tuberculin test	**Yr. last given** __	**Result** _____
Other	_____	_____
Typhoid and Paratyphoid	_____	_____
Cholera	_____	_____
Yellow Fever	_____	_____
Typhus	_____	_____
Rocky Mountain Spotted Fever	_____	_____

This person is in satisfactory condition and may engage in all usual activities except as noted.
Licensed physician's name:

_____

Licensed physician's signature:

_____

Address_____

City _____ **State** _____ **Zip**_____

Phone(_____**)** _____ **Date**_____

PLEASE LIST CURRENT MEDICATIONS BEING TAKEN ON SEPARATE PAPER AND ATTACH— INCLUDE DOSAGE AND ANY POTENTIAL HARMFUL INTERACTIONS (e.g. food, medications, environmental)

HEALTH INFORMATION PRIVACY STATEMENT

The Girl Health Examination Record **is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.**

Signature:_____**Date:**_____
(Parent/Guardian)