



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
Heart defect/disease Hay fever
Seizures Ivy poisoning, etc.
Diabetes Penicillin
Bleeding/clotting disorders Asthma
Musculoskeletal disorders Insects
Chicken Pox
Measles
German Measles
Mumps

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