GIRL SCOUTS OF MONTEREY BAY
MEDICAL EXAMINATION RECORD

To be filled in by physician after review of health history with parent/guardian

A health examination or written statement from your daughter's physician granting her permission to participate in strenuous activity such as water sports, horseback riding, hiking and non-contact sports such as track, tennis, or gymnastics **is required if (1) your daughter has not had a health examination in the previous two years, (2) for trips over three days, (3) resident camp (needed every 12 months), and (4) has had a serious injury or operation since her last health examination.**

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Health Examination:

Date of 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
X Not satisfactory
O Not examined

Nose _____

Throat_____

Teeth_____

Heart_____

Lungs_____

Abdomen_____

Genitalia_____

Hernia_____

Skin_____

Musculoskeletal_____

General physical and emotional status_____

Urinalysis*_____HGB*_____

Other notes_____

_____

_____

Record of immunizations:

Immunization	Year Primary Series Completed	Year Of Last Booster
D.P.T.	_____	_____
Diphtheria	_____	_____
Pertussis (Whooping Cough)	_____	_____
Tetanus	_____	_____
Td	_____	_____
Oral Polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Hbpv	_____	_____
Tuberculin test	Type _____	_____
	Year Last given _____	
	Result_____	
Other	_____	_____

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

_____

_____

_____

This person is in satisfactory condition and may engage in all usual activities except as noted.

***Not required** for every health examination. A Daisy, Brownie, or Junior Girl Scout should have this test if she has not already had it, either when entering school or at any time since. A Cadette or Senior Girl Scout should have this test if she has not had it since entering puberty.

Licensed physician's name_____

Licensed physician's signature _____

Address _____

City _____State _____Zip _____

(Area Code) Phone _____ Date _____

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