

CAMPER HEALTH EXAMINATION RECORD

THIS PORTION TO BE FILLED IN BY PARENT AND REVIEWED WITH PHYSICIAN AT THE TIME OF EXAMINATION

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

Health History: (Check those that apply)

- Chicken Pox
- Measles
- German Measles
- Mumps

Allergies

- Animals
- Food
- Hay Fever
- Insect Stings
- Medicine/Drugs
- Plants
- Pollen
- Other

Chronic or Recurring Illnesses

- ADD/ADHD
- Asthma
- Bleeding Disorders
- Diabetes
- Ear Infections
- Heart Defect/Disease
- Hypertension
- Musculoskeletal Disorders
- Seizures
- Other (Specify) _____

Suggestions From Parent:

PROGRAM SESSION ATTENDING

DATE ATTENDING

COMMENTS WHERE APPLICABLE:

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 correct and my camper has permission to engage in all prescribed activities, except as noted by me and the examining physician.

Signature of Parent/Guardian _____ Date _____

THIS PORTION TO BE FILLED IN BY PHYSICIAN AFTER REVIEW OF HEALTH HISTORY WITH PARENT/GUARDIAN.

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 ✓
 Not Satisfactory X
 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.T.P.	_____	_____
Diphtheria	_____	_____
Pertussis (Whooping Cough)	_____	_____
Tetanus	_____	_____
Td**	_____	_____
Oral polio	_____	_____
Measles	_____	_____
Mumps	_____	_____
Hib***	_____	_____
Hbpv***	_____	_____
Tuberculin test	Type _____ Year last given _____ Result _____	_____
COVID-19	_____	_____

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.

Licensed physician's name _____

Licensed physician's signature _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Date _____

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

**Adult tetanus-diphtheria toxoid

*** Haemophilus influenza b