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)_____

COMMENTS WHERE APPLICABLE:

Operations or serious injuries _____
Hospitalizations _____
Other diseases/disabilities _____

Suggestions From Parent:

PROGRAM SESSION ATTENDING

DATE ATTENDING

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 ✗
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