

Scout Name: _____

HEALTH EXAMINATION

Supplemental to Girl Medical History for Trips

THIS EXAMINATION IS TO BE GIVEN AND RECORDED BY A CALIFORNIA LICENSED MEDICAL PROFESSIONAL

EXAMINATION

This examination is to be performed within 24 months of trip. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in planned activities. Please note any abnormalities or illness.

Code: V: Satisfactory X: Not Satisfactory O: Not Examined

DATE OF EXAM: _____ WAS PARENT/GUARDIAN PRESENT AT EXAM? YES NO

GENERAL CONDTION: _____ TEMPERATURE: _____

HEIGHT: _____ WEIGHT: _____ B.P.: _____ HCT or HGB TEST (optional): _____ URINE (optional): _____

EYES (Glasses): _____ NOSE: _____ EARS: _____ LUNGS: _____

THROAT: _____ ABDOMEN: _____ HEART: _____ HERNIA: _____

POSTURE (SPINE): _____ FEET: _____ EXTREMITIES: _____ SKIN: _____

TEETH: NUMBER OF CARIES _____ ALLERGIES (PLEASE SPECIFY): _____

Has this person menstruated? _____ If so, is her menstrual history normal? _____

ADDITIONAL COMMENTS & RECOMMENDATIONS OR RESTRICTIONS:

INDICATE CONTINUING MEDICAL TREATMENT. (PLEASE GIVE SPECIFIC INSTRUCTIONS FOR CONTINUED CARE)

I HEREBY STATE THIS GIRL, WITH NOTED EXCEPTION, IS IN APPARENT GOOD HEALTH AND PHYSICALLY ABLE TO PARTICIPATE IN NORMAL AND STATED ACTIVITIES .

PHYSICIAN'S NAME (PLEASE PRINT) _____

PHYSICIAN'S SIGNATURE _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE () _____

MEDICAL FORMS ARE SUBMITTED TO AND KEPT WITH FIRST AIDER FOR TRIP