

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 CONDITON: \_\_\_\_\_ 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**