GIRL SCOUTS OF THE PHILIPPINES
NATIONAL HEADQUARTERS
MANILA

HEALTH EXAMINATION FORM

Name _____ Birth Date _____
Surname First Middle

Parent Guardian _____ Phone _____

Home Address _____
Street & Number Town/City Province

In case of emergency notify _____ Phone _____

Address _____

HEALTH HISTORY: (check - giving approximate dates)

Frequent Colds _____ Kidney Trouble _____ Chickenpox _____

Abscessed Ears _____ Convulsion _____ Mumps _____

Fainting _____ Sleep Walking _____ Whooping Cough _____

Frequent Sore Throats _____ Measles _____

Sinusitis _____ Heart Trouble _____

Bronchitis _____ Rheumatic Fever _____

Stomach Upset _____ Athlete's Foot _____

Constipation _____ Tuberculosis _____

Operations or serious injuries _____ Diabetes _____

Allergic Reactions:
Penicillin _____ Other Drugs _____

Details of above or additional information _____

Any specific activites to be encouraged? _____
Restricted? _____

IMPORTANT : Please notify the camp if this applicant is exposed to any communicable disease during the three weeks prior to camp attendance.

Suggestions fron Parent/Guardian

_____ :
_____ :
_____ :
_____ :
_____ :
_____ :
_____ :

_____
in case of Surgical Emergency
I hereby give permission to the physician selected by the camp director to hospitalize, secure prior treatment for, and to order injection, anesthesia or surgery for my daughter as named above.

Signature _____
Date _____

PHYSICAL EXAMINATION - to be filled out by licensed physician
Code V - Satisfactory
X - Not Satisfactory (explain)

Height _____ Blood Pressure _____ Circulatory System _____ Blood Analysis _____

Weight _____ Urinalysis _____
Eyes _____ Loco-motor System _____
Eye glasses _____ Nervous System _____
Ears _____ Skin _____
Nose _____ Allergy - Please specify
Throat _____ _____
Teeth _____
Heart _____ General Appraisal _____
Lungs _____ Menstrual History _____
Abdomen _____
Genitalia _____
Kernia _____

Recommendations and restrictions (diet, medicine, swimming, diving, etc.)

_____
_____

_____
_____

Immunizations:

D.P.T Series _____ Booster _____ Date _____ Tetanus Booster _____ Date _____
Typhoid Series _____ Booster _____ Date _____ (if requires by camp)
Small Pox _____ Date _____

_____
Examining Physician

Telephone _____ Address _____

Date _____

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