

GIRL HEALTH EXAMINATION RECORD

This part to be filled in by parent and reviewed with physician at the time of examination

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

Insurance Information, please complete the following:

Carrier	ID Number	Group Number
Member Services Phone Number	Address	

Health History: (Check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions From Parent:
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney	<input type="checkbox"/> Animals _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Hay Fever _____ <input type="checkbox"/> Insect Stings _____ <input type="checkbox"/> Medicine/Drugs _____ <input type="checkbox"/> Plants _____ <input type="checkbox"/> Pollen _____ <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other _____	<p>My daughter has permission to take or use the following:</p> { } Tylenol/Acetaminophen { } Advil/Ibuprofen { } Sudafed/decongestant { } Benadryl/antihistamine { } Pepto Bismol { } Tums/antacid { } Robitussin/expectorant { } Swimmers' Ear/alcohol-vinegar solution

Please describe conditions and give dates:

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 complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.

Signature of Parent/Guardian _____ **Date** _____

