

## GIRL HEALTH EXAMINATION RECORD

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

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

**Insurance Information, please complete the following:**

<b>Carrier</b>	<b>ID Number</b>	<b>Group Number</b>
<b>Member Services Phone Number</b>	<b>Address</b>	

**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><b>My daughter has permission to take or use the following:</b></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** \_\_\_\_\_

