



# ADULT HEALTH EXAMINATION FORM

Girl Scouts of the U.S.A.  
830 Third Avenue  
New York, NY 10022

**Name of Applicant – Last, First, Middle** **Sex** **Date of Birth**

**Address** **City** **State** **Zip** **(country)**

**In Emergency Notify: Name** **Address** **Phone (Area Code)** **Relationship**

**Health History** – Check if you have had any of the following:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Eyesight Impairment             | <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Intestinal Disorders |
| <input type="checkbox"/> Hearing Impairment              | <input type="checkbox"/> Rheumatic Fever               | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Chicken Pox          |
| <input type="checkbox"/> Speech Impairment               | <input type="checkbox"/> Abnormal Blood Pressure       | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Measles              |
| <input type="checkbox"/> Disorders of the Nervous System | <input type="checkbox"/> Mental or Emotional Disorders | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Mumps                |
| <input type="checkbox"/> Sinusitis                       | <input type="checkbox"/> Disease of Ears               | <input type="checkbox"/> Hay fever or Asthma     | <input type="checkbox"/> German Measles       |
| <input type="checkbox"/> Disease of Kidneys              | <input type="checkbox"/> Severe Menstrual Pain         | <input type="checkbox"/> Other Serious Allergies |   |
- Have you been hospitalized in the last five years?  Yes  No      Are you taking any medications? Explain

If you have checked or answered yes to any of the above, give nature, dates, period of any disability and results:

I certify that to the best of my knowledge I am in good health and able to participate in this event/assignment.

**Signature of Applicant** **Date**

**Physician** – Please complete remainder of application

Instructions: Please ask applicant to show you a written description of the event/assignment so that you may determine whether she/he is in condition to participate in this particular event/assignment and to insure that the applicant has the valid Immunizations required.

**Examination Findings** – Check box if condition is satisfactory. If not satisfactory, explain in space provided.

- |  |   |  |                                  |
|--|---|--|----------------------------------|
| <input type="checkbox"/> Eyes and Vision | <input type="checkbox"/> Ears and Hearing | <input type="checkbox"/> Menstrual Periods                       | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Skin            | <input type="checkbox"/> Heart            | <input type="checkbox"/> Chest X-ray (If Required)               |                                  |
| <input type="checkbox"/> Throat          | <input type="checkbox"/> Lungs            | <input type="checkbox"/> Legs (Cramping or Primitive Conditions) |                                  |

Exact Measurements of:

Blood Pressure	Pulse Rate	Urinalysis	Sugar	Albumen	Blood Hemoglobin	Height	Weight
Systolic    Diastolic		SP Gravity					

- Does Applicant have any condition which might limit activity for this event/assignment?  Yes  No
- Does applicant have any chronic diseases?  Yes  No      If overweight will condition restrict activity?  Yes  No
- Does applicant have any conditions which might limit her/his participation in swimming, hill climbing and other strenuous activities?  Yes  No

**Immunizations** – Fill in date of valid immunizations, applicant has had. Only those requested on the announcement of the event/assignment are required.

Immunization	Date last Received	Immunization	Date Last received
Smallpox Vaccination		Typhoid and Paratyphoid	
Tetanus		Cholera	
Typhus		Yellow Fever	
Polio – Complete series or Booster required		Gamma Globulin (Hepatitis)	
Rocky Mountain Spotted Fever (entire series)		Other	
German Measles			

**Statement of Physician**  Applicant is in good physical condition and will be able to participate in this event/assignment?  
 Applicant should not participate in this event for the following reasons:

**Name of Physician** **Signature** **Address**

**Health History at Event/Assignment**