

Girl Health History Record

This health history is to be completed and signed by parents/guardians of girls.

Girl's name:	Phone:	Name of family physician:
Family medical/hospital insurance carrier:	Policy or group no.	Physician phone: ()

- Illnesses and injuries:** (Check those that apply.)
- | | | | |
|---|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Ear infection | <input type="checkbox"/> Bleeding/clotting disorders | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart defect/disease | <input type="checkbox"/> Musculo-skeletal disorders | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
- Other (specify) _____

Date of last health examination: _____

Were any complicating medical problems noted in last health examination? _____

Allergies: (Check those that apply and specify nature of allergic reaction.)

- | | |
|--|--|
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Hay fever _____ |
| <input type="checkbox"/> Pollen _____ | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Medicines/drugs _____ | <input type="checkbox"/> Insect stings _____ |
| <input type="checkbox"/> Plants _____ | <input type="checkbox"/> Other (specify) _____ |

Other health conditions: (Check those that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Emotional disturbances |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Sickle cell trait or disease |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Special dietary regimen |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Wears glasses or contact lenses |
| <input type="checkbox"/> Other (specify) _____ | |

Immunization History:

Immunization	Year Primary Series Completed	Year of Last Booster
DTP	_____	_____
Diphtheria		
Pertussis (whooping cough)		
Tetanus		
TB		
Measles	_____	_____
Mumps	_____	_____
Rubella (German Measles)	_____	_____
Oral Polio	_____	_____
Other (specify) _____		

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

I know of no reason(s), other than the information indicated on this form, why my daughter should not participate in prescribed activities except as noted.

Signature of parent/guardian _____ Date _____

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- Other (specify) _____

Date of last health examination: _____

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