Minor Health History and Medical Examination

Medical Examination: This page (3) must be completed by a licensed professional as listed above, once they have reviewed the completed and signed Health History (pages 1 & 2).

Patient Name:	**Patient Date of Birth:**

Height		Nose		Musculoskeletal	
Weight		Throat		Appearance	
Pulse		Heart		General Physical State	
BP		Lungs		General Mental State	
Hearing		Skin		Other	
Eyes		Abdomen		Other	

Immunization Record	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, Tetanus, Pertussis (DTaP) or (TdaP)						
Tetanus Booster (Tdap) or (Td)						
Mumps, Measles, Rubella,(MMR)						
Polio (I P V)						
Haemophiles Influenzae Type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) Had chicken pox Date:						
Meningococcal Meningitis (MCV4)						
COVID 19						
Tuberculosis (TB) test	Date:	Negative ☐ Positive ☐				

Patient Acknowledgment of Non- Immunization

If the patient has not been fully immunized, please have their parent/guardian sign the following statement: I understand and accept the risks that may come from not being fully immunized and do not hold Girl Scouts of Citrus Council, or any related entities responsible.

Parent/Guardian Signature: _____ Date: _____

Does this patient have any physical limitations/conditions which might limit any activity for this event/trip? ◯Yes ◯ No
If yes, please explain:_____

Should they limit their participation in swimming or other strenuous activity? ◯ Yes ◯No
If yes, please explain: _____

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted. Yes, please initial _____

Licensed Physician Name: (Last, First, Middle Initial)	Phone Number:		
Address:	City:	St:	Zip:

Signature of Licensed Physician: _____State License Number: _____Date: _____