

Last Name:	First Name:	Date of Birth:
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**2019 HEALTH EXAMINATION FORM:
Health Care Recommendations by Licensed Medical Personnel**

I examined this individual on (date): _____ .

*(Girl Scouts of Greater Los Angeles policies **require** exams within 12 months of desert ending date - exam must be after April 8, 2018.)*

Ht. _____ Wt. _____ BP: _____

In my opinion, this individual is/is not able to participate in an active, primitive camp program (please circle one for each activity):

Camping	YES	NO	Rock Climbing	YES	NO	Rappelling	YES	NO
Zip Lining	YES	NO	Backpacking	YES	NO	Hiking	YES	NO

This individual is under the care of a physician for the following conditions:

Medications, Recommendations, and Restrictions at Camp:

Signature of Licensed Medical Personnel: _____

Printed Name: _____

Title: _____

Address: _____

Phone #: _____

Date Signed: _____

Doctor's Office Stamp