Last Name:	**First Name:**	**Date of Birth:**

2020 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 9, 2019.)*

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

MPE HEALTH EXAM FORM / UPDATED 09/2019
PLEASE RETURN TO MPE REGISTRAR NO LATER THAN MARCH 7, 2020