

**PERSONAL HEALTH AND MEDICAL RECORD
CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY
(Annually by all participants)**

To be filled out by parent, guardian, or adult participant. **Please print in ink.** District: _____ PACK # _____

Name _____ Date of Birth _____ Age _____ Sex _____

Name of parent or guardian _____ Telephone (H) _____ & (B) _____

Home address _____ City _____ St _____ Zip _____

Business address _____ City _____ St _____ Zip _____

If person named above is not available in the event of an emergency, notify

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of personal physician _____ Telephone _____

Personal health /accident insurance carrier _____ Policy No. _____

Check all items that apply, past or present, to you health history. Explain any "YES" answers.

ALLERGIES: Food, medicines, insects, plants: Yes No Explain: _____

GENERAL INFORMATION:

	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Convulsion/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>			

Explain _____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or playing strenuous physical games: _____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (give date of last inoculation)

Tetanus toxoid _____ Measles _____ Polio _____ Diphtheria _____

Mumps _____ Pertussis _____ Rubella _____

In case of emergency, I understand every effort will be made to contact me (if an adult, my spouse or next of kin). In the event I cannot be reached. I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child (or for me, if an adult). Some hospitals require the parent/ guardian to be notarized. Check with your BSA local council.

Signature of parent/guardian or adult _____ Date: _____

ONLY FILL OUT SECTION BELOW IF SCOUT WILL NEED TO TAKE MEDICATION WHILE AT CAMP

The camp will not provide medication; all medications must be brought from home (including non-prescription drugs such as Tylenol, Benedryl, etc.) Medications must be checked in with the camp health officer daily. Medications must have the camper's name on them and be accompanied by the following written approval from parents.

AUTHORIZATION TO ADMINISTER MEDICATION

I, _____, parent/guardian of _____ hereby request that the Cub Scout Day Camp Health Officer administer the following medication to my child.

Medication Name _____ **Dosage** _____ **Circle days to be given**
M Tu W Th F **Time(s)** _____

Medication Name _____ **Dosage** _____ **M Tu W Th F** **Time(s)** _____

I also release the Cub Scout Day Camp staff and BSA from all liability whatsoever that may result from my child taking this medication

Parent/Guardian Signature: _____ Date: _____