

Class 1 Personal Health and Medical History
(To be filled out annually by all participants)

Cub Scout/ Scout/ Adult
Circle ONE

Recent Picture

Required for Day Camp

Optional for all other activities

To be filled out by parent, guardian or adult participant (Please print in ink.)

Participants name _____
 Date of Birth _____ Age _____ Sex _____
 Name of parent or guardian _____
 Home phone _____ Work phone _____
 Cell phone _____ Pager no. _____
 Home address _____ City _____
 Work Address _____ City _____
 If person named above is not available during an emergency, please contact:
 Name _____ Relationship _____ Home # _____ Work# _____
 Name _____ Relationship _____ Home # _____ Work# _____
 Name _____ Relationship _____ Home # _____ Work# _____
 Name of personal physician _____ phone# _____
 Personal health/accident insurance carrier _____ Policy# _____

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

Allergies: Food, medicines, insects, plants, etc. YES__ NO __ Explain _____

General Information:

ADHD (Attention-Deficit Hyperactivity Disorder)	Y	N	Seizures	Y	N	Heart trouble	Y	N
Asthma	Y	N	Convulsions	Y	N	High Blood Pressure	Y	N
Cancer/leukemia	Y	N	Diabetes	Y	N	Kidney trouble	Y	N
			Hemophilia	Y	N	Handicapping condition	Y	N

Explain: _____

Do you have or are you currently under treatment for any contagious infections or diseases? _____

Do you have any mental, emotional, or behavioral conditions that may affect or limit your full participation in camp activities? _____ Please explain _____

List any restrictions: _____

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

Medications to be taken at camp: _____

Immunizations: (give date of last inoculation)

Tetanus Toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	HIB _____
Pertussis _____	Rubella _____	HBV _____

My son may leave camp with the following people:

1. _____
2. _____
3. _____
4. _____

I give permission for full participation in BSA programs, subject to limitations noted herein. IN CASE OF EMERGENCY, I understand every effort will be made to contact me (my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child or myself. (some hospitals require the signature to be notarized. Please check with your local hospital / doctor)

Date _____ Signature of parent/guardian or adult _____