

Health History

Circle one: Youth Adult Sibling District _____ Pack # _____

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Phone home _____ Work _____ Cell/ Pager _____

Physician's Name _____ Phone _____

Health Insurance Company _____ Policy# _____

Alternate Contact (not parents) _____ Phone _____

Check all items that apply, past or present. Explain below any that are checked, use back if necessary

Allergies to medication, food, plant, insects _____

Asthma Fainting Spells Convulsions/seizures High blood pressure

Diabetic Heart Trouble Bleeding Disorder Other significant medical problem

Do you have difficulty with Eyes, ears, nose, throat Digestion Lungs Sleepwalking
 Mental Illness ADHD

Explain: _____

Physical or behavioral condition that the staff should be aware _____

Requires special equipment, or diet _____

Restrictions from activity; explain _____

All medications presently taking: _____

Cub Scouts are NOT ALLOWED to have any medications in their possession (including over the counter), except for Epi-Pens or Inhalers. These medications must be reported to the camp health officer.

Camp is not responsible for administering medication. Record medications to be taken at camp and person administering them: _____

Immunization: Give date of last inoculation Tetanus toxoid _____ Polio _____ Measles _____
Rubella _____ Diphtheria _____ Pertussis _____ Mumps _____

Consent for Emergency Treatment (must be signed)

This health history is correct so far as I know and the person herein described, has permission to engage in all prescribed activities, except as noted by me. I will not send my child if he has a **Fever**, any **contagious condition**, or for any reason that I do not consider him to be in good health. In the event I cannot be reached in an emergency, I hereby give my permission to medical personal to secure proper treatment including hospitalization, anesthesia, surgery or injection for my child/ward (or for myself)

Parent/Guardian signature _____ Relationship _____

Printed Name of Signature above _____ Date _____

Address _____ City/State/Zip _____

Required if different than above address

Home Phone _____ Work Phone _____

Beeper _____ Cell Phone _____ Fax No. _____