PERSONAL HEALTH AND MEDICAL RECORD

Class 1

To be filled in for all Cub Scout, adult and sibling participants. This form will not be returned. Please make a copy and retain for your records. This health form should be filled out for the applicant on the other side of the paper (if two-sided).

Please print legibly in ink

IDENTIFICATION:

Name: ____Date of Birth ________________________Age: ____ Sex: ____

Home Address: ______________________________________ City: __________________ State: _____ Zip: _________

Emergency Parent / Spouse/ Family Member: ______________________________ Daytime Phone: (_____) _______________

Business Address: ____________________________________City: __________________ State: _____ Zip: _________

Business Phone: (_________) ___________________EXT. _____ E-mail:_________________________________ __

If parent/guardian above is not available in the event of an emergence, notify person listed below
(Must be someone who can pick up your child if you cannot. Please list at least one other than the parents)

Name: ____ Relationship: ___________________ Phone: ____________

Name: ____ Relationship: ___________________ Phone: ____________

Name of personal physician: ____ Phone: (_____)_________________

Personal health / accident insurance carrier: _______________________________ Policy No.: ____________________

CHECK ALL ITEMS THAT APPLY, PAST OR PRESENT, TO YOUR HEALTH HISTORY - GIVE DETAILS FOR ANY "YES" ANSWERS

ALLERGIES: Food, medication, insects, plants, etc. [ ] Yes [ ] No Describe: ________________________________

GENERAL INFORMATION:

	YES	NO		YES	NO		YES	NO
Asthma	[ ]	[ ]	Diabetes	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Cancer / Leukemia	[ ]	[ ]	Heart Trouble	[ ]	[ ]	Kidney Disease	[ ]	[ ]
Convulsions / Seizures	[ ]	[ ]	Hemophilia	[ ]	[ ]	ADD / ADHD	[ ]	[ ]

[ ] Other Medical Problems(please list)____

Explain with details any "Yes" answers above: ____

List all medications taken: ____

List all 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 DATES OF LAST INOCULATIONS OR INFECTION)**

_______ **UP TO DATE FOR AGE AS REQUIRED FOR PUBLIC SCHOOL**

Tetanus toxoid__________________ Measles ______________________ Polio ___________________________

Diphtheria ______________________ Mumps ______________________ Hep B ___________________________

Pertussis ______________________ Rubella ______________________ Varicella_________________________
(Chicken Pox Vaccine)

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 medication for my child or for me, if an adult.

Signature of Parent / Guardian or Adult : Date: / /