OKAW VALLEY COUNCIL, BOY SCOUTS AMERICA
2007 HEALTH HISTORY FORM

Complete a separate form for EACH person who will be spending time at Day Camp

(This includes the Scouts, leaders and family members)

Name: _____ Age: _____ Pack #: _____

Does this person have or is subject to: (check if yes)

[ ] Asthma [ ] Fainting spells [ ] Convulsions [ ] Diabetes

[ ] Insect bites [ ] Heart trouble [ ] Allergies to: _____

Special Medical Considerations: _____

Have difficulty with: (check if yes) [ ] Eyes [ ] Ears [ ] Nose [ ] Throat [ ] Lungs [ ] Digestion

Condition requiring regular medication? [ ] Yes [ ] No. Which medication?_____

Any restrictions for medical reasons? [ ] Yes [ ] No. Describe: _____

In Case of Emergency

Name: _____Phone: _____2nd Phone: _____

Relationship to Scout:_____Physician Name: _____ Phone: _____

Insurance Carrier: _____ Policy/Group # _____

PARENT AUTHORIZATION: This health history is correct so far as I know, and the person herein described has my permission to engage in all prescribed activities, except as noted by me and/or the physician. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to treat as necessary including hospitalization, proper anesthesia or to order injections or surgery for my son.

Signed: _____ Date: _____

Parent email: _____

By submitting this application, I understand that my Scout may be photographed or videotaped, solely for Scouting purposes.