NAME ______ Unit # ______ Day Camp

Check all items that apply, **past or present**, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, medicines, insects, plants Yes ☐ No ☐ Explain: ____________________

GENERAL INFORMATION:

	Yes	No		Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder	☐	☐	Convulsions/seizures	☐	☐	Hemophilia	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cancer/leukemia	☐	☐	Heart trouble	☐	☐	Kidney disease	☐	☐

Explain: ____________________

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: ____________________

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	______		______

<u>Medication #1</u> (to be filled in by parent/guardian)

Name of medication: ______

Dosage ______

Date medication to begin: ______

Purpose of medication ______

Possible side effects: ______

______

Time of administration: ______

<u>Meds dispensed by Medical Staff</u>

Monday ______ Initial ______

Tuesday ______ Initial ______

Wednesday ______ Initial ______

Thursday ______ Initial ______

<u>Medication #2</u> (to be filled in by parent/guardian)

Name of medication: ______

Dosage ______

Date medication to begin: ______

Purpose of medication ______

Possible side effects: ______

______

Time of administration: ______

<u>Meds dispensed by Medical Staff</u>

Monday ______ Initial ______

Tuesday ______ Initial ______

Wednesday ______ Initial ______

Thursday ______ Initial ______

Copy and fill out additional forms as required. Be sure to attach all of the forms for each child together.

This form must be completed by the parent guardian and the Camp Medical Staff must maintain a copy. After check in, proceed to the Camp Medical Station and give the medications to the Medical Staff.

All medication shall be in their original containers as dispensed by the Pharmacist with the patient's name, physician's name, date dispensed, prescription number, and name of the medication and dosage requirements clearly labeled on the container.

Asthma inhalers and bee sting kits should be kept with the Scout, but with written instruction from the parent. This release form is still required to be turned into the Medical Staff even if the Scout carries his inhaler or sting kit with him. The Medical Staff shall be kept aware of any person carrying this type of medication with them.

If your Scout requires medication just once per day, it is requested that your Scout take his medication either before or after Camp and not at Camp.

Parent Guardian Name: ______ Signature ______

Address ______ City ______ Emergency Phone Number(s) ______

Pack # ______ Pack Coordinator name ______ ______

Medical Staff review by: ______ Date ______