

PERSONAL HEALTH AND MEDICAL RECORD

Class 1

To be filled in for all Cub Scout, adult volunteers, Den Chiefs and sibling participants. This form will not be returned. Please make a copy and retain for your records. This health record 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. _____

If parent/guardian above is not available in the event of an emergency, notify person listed below
(Must be someone who can pick up your child if you can not. 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	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer / Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>
[<input type="checkbox"/>] 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: / /