Health Information for Cub Scouts

Boy Scouts of America

Name___________________________________Age ___________Pack No. ____________________

Address___________________________City/State_________________________Zip________________

IN CASE OF EMERGENCY NOTIFY:

Name___________________________________Daytime Phone_________________________________

Cell Phone________________________________Other Contact Phone______________________________

Relationship [ ]Parent [ ]Guardian [ ]Other

Address___________________________City/State_________________________Zip________________

Family Physician____Phone____________________________

<u>Health History</u>

Has or is subject to: [Check if "yes"]

[ ]Asthma [ ]Inhaler [ ]Fainting [ ]Convulsions [ ]Diabetes

[ ]Heart Trouble [ ]ADD/ADHD w/Medication [ ]Swimming/Sports Restriction

Allergies: [ ]Medication [ ]Food [ ]Insects [ ]Epipen

[ ]Other___________________________Describe____

Has Difficulty with: [Check if "Yes"]

[ ]Eyes [ ]Ears [ ]Nose [ ]Throat [ ]Lungs [ ]Digestion

[ ]Any condition requiring medication?____

[ ]Is his/her medication with him/her? If not, who has it?____

[ ]Any restriction of activity for medical reasons?____

Explain:____

Parent Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all activities, except as noted by the physician and me. In the event, I cannot be reached in an emergency, I hereby give permission to the physician, selected by the leader in charge, to hospitalize, secure proper anesthesia, or order injection or surgery for my child.

Signature:_______________________________________ Date:_____________________________

Parent or Guardian