

PERSONAL HEALTH AND MEDICAL RECORD
CLASS 1- FOR CUB SCOUT DAY CAMP ONLY!

CLASS I- (Update annually for all participants). Activity: Day Camp, overnight hike, or other programs not exceeding 72 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

IDENTIFICATION

To be filled out by parent, guardian or adult participant. Please print in ink.

Name Date of Birth / / Age Sex

Name of Parent or Guardian Home Phone ()

Business Phone () Home Address City

If the above named person is not available in case of an emergency, please provide names and phone numbers of someone able to pick up your child if the need arises.

Name Relationship Phone/Cell/Pager ()

Name Relationship Phone/Cell/Pager ()

MEDICAL INFORMATION

Name of Personal Physician Phone ()

Personal health/accident carrier Policy

List any medication to be taken at Camp:

Allergies: Check if they apply: Food Medicines Insects Plants Explain:

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

Table with 7 columns: General Information, Yes, No, Yes, No, Yes, No. Rows include Asthma, Cancer/Leukemia, Convulsions/Seizures, Diabetes, Heart Trouble, Hemophilia, High Blood Pressure, Kidney Disease, Other.

Explain:

List any physical or behavioral conditions that may effect or limit full participation in swimming, backpacking, hiking long distances, playing strenuous games or activities:

List equipment needed such as wheelchairs, braces, glasses, contact lenses, etc:

Immunizations: (Give date of last inoculation)

Tetanus Measles Polio
Diphtheria Mumps Other
Pertussis Rubella Other

I give my permission for full participation in the BSA program, subject to limitations noted herein.

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 treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

Date Signature of Parent/guardian/or adult

Some hospitals require the parent/guardian signature to be notarized. Check with your local council.

Note: Some states require an annual pre-camp medical evaluation. Your BSA Local Council Service Center can advise you about the requirements for your state.

Name
LAST
FIRST
Pack:
District: