Class 1 Personal Health and Medical History
(To be filled out annually by all participants)

Cub Scout/ Scout/ Adult
Circle ONE

Recent Picture

Required for Day Camp

Optional for all other activities

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

Participants name _____
Date of Birth _____ **Age** _____ **Sex** _____
Name of parent or guardian _____
Home phone _____ **Work phone** _____
Cell phone _____ **Pager no.** _____
Home address _____ **City** _____
Work Address _____ **City** _____
If person named above is not available during an emergency, please contact:
Name _____ **Relationship** _____ **Home #** _____ **Work#** _____
Name _____ **Relationship** _____ **Home #** _____ **Work#** _____
Name _____ **Relationship** _____ **Home #** _____ **Work#** _____
Name of personal physician _____ **phone#** _____
Personal health/accident insurance carrier _____ **Policy#** _____

Check all items that apply, past or present, to you health history. Explain any "YES" answers.
Allergies: Food, medicines, insects, plants, etc. YES__ NO __ Explain _____
General Information:

ADHD (Attention-Deficit Hyperactivity Disorder)	**Y**	**N**	**Seizures**	**Y**	**N**	**Heart trouble**	**Y**	**N**
			Convulsions	**Y**	**N**	**High Blood Pressure**	**Y**	**N**
Asthma	**Y**	**N**	**Diabetes**	**Y**	**N**	**Kidney trouble**	**Y**	**N**
Cancer/leukemia	**Y**	**N**	**Hemophilia**	**Y**	**N**	**Handicapping condition**	**Y**	**N**

Explain: _____

Medications to be taken at camp: _____
List any physical, mental, emotional, or behavioral conditions that may affect or limit full participation in swimming, hiking or engaging in strenuous physical activity: _____
List any restrictions: _____
List any equipment needed such as wheelchair, braces, glasses, contact lenses, etc.: _____

Immunizations: (give date of last inoculation)

Tetanus Toxoid _____	**Measles** _____	**Polio** _____
Diphtheria _____	**Mumps** _____	**HIB** _____
Pertussis _____	**Rubella** _____	**HBV** _____

My son may leave camp with the following people:
1. _____ **2.** _____
3. _____ **4.** _____

I give permission for full participation in BSA programs, subject to limitations noted herein. IN CASE OF EMERGENCY, I understand every effort will be made to contact me (my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child or myself. (some hospitals require the signature to be notarized. Please check with your local hospital / doctor)
Date _____ **Signature of parent/guardian or adult** _____