

PERSONAL HEALTH AND MEDICAL HISTORY

Note: You can edit this with Acrobat Reader

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

IDENTIFICATION

Name _____ Date of Birth _____ Age ____ Sex ____

Name of parent or Guardian _____ Telephone _____

Home address _____ City _____ State ____ Zip _____

Business address _____ City _____ State ____ Zip _____

If person named above is not available, in the event of an emergency, notify:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name of Physician _____ Telephone _____

Personal Insurance carrier _____ Policy No. _____

Note: 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 (if participant is an adult - 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 for me, if participant is an adult).

Date _____ Signature of parent/guardian or adult _____

Date updated _____ Signature of parent/guardian or adult _____

Date updated _____ Signature of parent/guardian or adult _____

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

ADHD	Yes	No	Hemophilia	Yes	No	High blood pressure	Yes	No
Asthma	Yes	No	Diabetes	Yes	No	Convulsions/seizures	Yes	No
Kidney disease	Yes	No	Cancer/leukemia	Yes	No	Heart trouble	Yes	No

Explain: _____

ALLERGIES: Food Yes No Medicines Yes No Insects Yes No Plants Yes No

Explain: _____

List any medications to be taken at camp (send ample supplies and directions for use):

List any physical or behavioral conditions that may affect or limit full participation (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 _____	Polio _____	Measles _____
Diphtheria _____	Pertussis _____	Mumps _____
		Rubella _____