

Personal Health and Medical Record
Class 1

Fill in this form for all day camp participants; including cub scouts, adults and siblings. This form will not be returned to you. Please make a copy and retain for your records.

To be completed annually by Parent/Guardian or Adult Participant.

Please Print in Ink

Identification	<input type="checkbox"/>	Scout	<input type="checkbox"/>	Adult (18 & Older)	<input type="checkbox"/>	Sibling
Name: _____ Date of Birth _____ Age _____ Sex _____						
Name of Parent/Guardian: _____ Home Phone: _____						
Work Phone: _____ Cell Phone: _____						
Home Address: _____ City: _____ State: _____ Zip: _____						
If person above is not available in the event of an emergency, notify:						
Name: _____ Relationship: _____ Phone #: _____						
Name: _____ Relationship: _____ Phone #: _____						
Name of Personal Physician: _____ Phone #: _____						
Personal Health/Accident Insurance Carrier: _____						
Policy Number: _____						

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

ALLERGIES: Food, Medicines, Insects, Plants Yes No Explain: _____

General Information:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Attention Disorder Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemophillia	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Eyes, Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>			Takes Prescriptions Daily	<input type="checkbox"/>	<input type="checkbox"/>	

Explain: _____

List any medications to be taken at camp: _____

List any physical or behavioral conditions that may affect or limit full participation in any day camp activities: _____

List equipment needed such as wheelchairs, braces, glasses, etc. _____

ALL MEDICATIONS NEED TO BE CHECKED IN WITH THE CAMP MEDIC AND BE IN THE ORIGINAL PHARMACY CONTAINER WITH THE PATIENTS NAME AND DOSAGE CLEARLY MARKED. THIS INCLUDES ALL OVER THE COUNTER MEDICATIONS.

IMMUNIZATIONS: (Give Date of last inoculation)

Tetanus Toxoid: _____	Measles: _____	Polio: _____
Diphtheria: _____	Mumps: _____	Hepatitis B: _____
Pertussis: _____	Rubella: _____	

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).

Date: _____ Signature of parent/guardian or adult: _____