

MEDICAL
INFORMATION

Pack _____

This completed health form must be on file for every person attending day camp. No one may participate in camp if this form is not on file.

Please Circle Week(s) Attending: WEEK 1 WEEK 2

LAST NAME: _____ FIRST NAME: _____

Check One: Cub Scout Tiger Cub Gatorbite Volunteer Boy Scout Jr. Volunteer

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Age: _____ Weight: _____ Home #: _____ Work #: _____ Cell #: _____

IN CASE OF EMERGENCY NOTIFY:

NAME: _____ Relationship: _____ Phone: _____

NAME: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Personal health/accident insurance carrier: _____ Policy #: _____

HEALTH HISTORY (Check all items that apply, past or present, and explain any checked answers.)

- | | | |
|---|---|---|
| <input type="checkbox"/> ADHD/ADD* | <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma ** | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Allergies ** | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Cancer/Lukemia | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Physical Limitations |

Explanation: _____

(Please list any additional explanations, limitations or other medical conditions on the next page)

Medications & dosages taken on a regular basis: _____

With health officer? _____ With child or adult? (Specify) _____ Taken before camp? _____

***ADHD/ADD checked box requires that you continue your normal medication during the week of day camp. If medication is taken during camp yours, it should be given to the health officer.**

****Asthma and allergies require completion of the additional information on the next page.**

TREATMENT AUTHORIZATION

This health history is correct so far as I know, and I give permission for full participation in Day Camp, 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).

Signed: _____ Date: _____

(parent or guardian if child under 18 years of age)

PHYSICIAN'S SIGNATURE

(Required for anyone IF taking medication either at camp or before camp, or for any condition limiting activity):

M.D. Signature: _____ Date: _____

**ADDITIONAL MEDICAL
INFORMATION**

Pack _____

Only include this form if additional medical information is needed.

LAST NAME: _____ FIRST NAME: _____

Check One: Cub Scout Tiger Cub Gatorbite Volunteer Boy Scout Jr. Volunteer

Describe any pertinent health history, physical limitation or medical condition information below:

Asthma Information:

Typical Asthma trigger:
__ Allergies __ Physical Exertion __ Other

Typical Reaction:
__ Mild __ Moderate __ Severe

Medication (if any): _____

Prescription for above medication: __ Yes __ No

Medication with Health Officer? __ Yes __ No

Allergy Information:

Allergy Type: __
__ Food __ Medicines __ Insects __ Plants

Typical Reaction:
__ Mild __ Moderate __ Severe

Medication (if any): _____

Prescription for above medication? __ Yes __ No

Medication with Health Officer? __ Yes __ No

Allergy Information:

Allergy Type: __
__ Food __ Medicines __ Insects __ Plants

Typical Reaction:
__ Mild __ Moderate __ Severe

Medication (if any): _____

Prescription for above medication? __ Yes __ No

Medication with Health Officer? __ Yes __ No

Allergy Information:

Allergy Type: __
__ Food __ Medicines __ Insects __ Plants

Typical Reaction:
__ Mild __ Moderate __ Severe

Medication (if any): _____

Prescription for above medication? __ Yes __ No

Medication with Health Officer? __ Yes __ No