

# PERSONAL HEALTH AND MEDICAL RECORD

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_

## CLASS 1 PERSONAL HEALTH AND MEDICAL HISTORY (To be filled out annually by all participants)

### 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 personal physician \_\_\_\_\_ Telephone \_\_\_\_\_

Personal health/accident insurance carrier \_\_\_\_\_ Policy No. \_\_\_\_\_

Mark 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:

ADHD (Attention-Deficit Hyperactivity Disorder) YES NO Convulsions/seizures YES NO Hemophilia YES NO

Asthma YES NO Diabetes YES NO High blood pressure YES NO

Cancer/leukemia YES NO Heart trouble YES NO Kidney disease YES NO

Explain \_\_\_\_\_

Please list ALL medications taken in the 30 days **prior** to arrival at the Scouting activity where this form is to be used: \_\_\_\_\_

List any **medications to be taken at camp**, including drug, dosage, route (oral, injection, etc.), and frequency: \_\_\_\_\_

List any physical or behavior conditions that may affect or limit full participation in 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 \_\_\_\_\_ Measles \_\_\_\_\_ Polio \_\_\_\_\_

OR DPT \_\_\_\_\_ OR MMR \_\_\_\_\_ \_\_\_\_\_

Hepatitis A \_\_\_\_\_ Varicella \_\_\_\_\_ OR Chicken Pox \_\_\_\_\_

Hepatitis B \_\_\_\_\_

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 \_\_\_\_\_

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