

Health History

Circle one: Youth Adult Sibling District \_\_\_\_\_ Pack # \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone home \_\_\_\_\_ Work \_\_\_\_\_ Cell/ Pager \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_

Alternate Contact (not parents) \_\_\_\_\_ Phone \_\_\_\_\_

Check all items that apply, past or present. Explain below any that are checked, use back if necessary

- Allergies to medication, food, plant, insects \_\_\_\_\_
- Asthma       Fainting Spells       Convulsions/seizures       High blood pressure
- Diabetic       Heart Trouble       Bleeding Disorder       Other significant medical problem

Do you have difficulty with  Eyes, ears, nose, throat     Digestion     Lungs     Sleepwalking  
 Mental Illness                       ADHD

Explain: \_\_\_\_\_

- Physical or behavioral condition that the staff should be aware \_\_\_\_\_
- Requires special equipment, or diet \_\_\_\_\_
- Restrictions from activity; explain \_\_\_\_\_

All medications presently taking: \_\_\_\_\_

Cub Scouts are NOT ALLOWED to have any medications in their possession (including over the counter), except for Epi Pens or Inhalers. These medications must be reported to the camp health officer.

Camp is not responsible for administering medication. Record medications to be taken at camp and person administering them: \_\_\_\_\_

**Immunization:** Give date of last inoculation Tetanus toxoid \_\_\_\_\_ Polio \_\_\_\_\_ Measles \_\_\_\_\_  
Rubella \_\_\_\_\_ Diphtheria \_\_\_\_\_ Pertussis \_\_\_\_\_ Mumps \_\_\_\_\_

**Consent for Emergency Treatment (must be signed)**

This health history is correct so far as I know and the person herein described, has permission to engage in all prescribed activities, except as noted by me. I will not send my child if he has a **Fever**, any **contagious condition**, or for any reason that I do not consider him to be in good health. In the event I cannot be reached in an emergency, I hereby give my permission to medical personal to secure proper treatment including hospitalization, anesthesia, surgery or injection for my child/ward (or for myself)

Parent/Guardian signature \_\_\_\_\_ Relationship \_\_\_\_\_

Printed Name of Signature above \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
*Required if different than above address*

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Beeper \_\_\_\_\_ Cell Phone \_\_\_\_\_ Fax No. \_\_\_\_\_