National Capital Area Council, BSA

Cub Scout Day Camp

Unit Number
_____
Date(s) Treated
_____

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 [ ] Scout [ ] Adult (18 & Older) [ ] Sibling

Name: _____Date of Birth _____Age ____Sex_____

Name of Parent/Guardian: _____Home Phone: _____

Work Phone: _____ Cell Phone: _____

Home Address:_____City:_____State:_____Zip:_____

Email: _____

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:

	Yes	No		Yes	No		Yes	No
Asthma	[ ]	[ ]	Diabetes	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Attention Disorder Deficiency	[ ]	[ ]	Digestion	[ ]	[ ]	Kidney Disease	[ ]	[ ]
Cancer/Leukemia	[ ]	[ ]	Heart Trouble	[ ]	[ ]	Mental Illness	[ ]	[ ]
Convulsions/Seizures	[ ]	[ ]	Hemophillia	[ ]	[ ]	Lungs	[ ]	[ ]
Eyes, Ears, Nose, Throat	[ ]	[ ]				Takes Prescriptions Daily	[ ]	[ ]

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: _____