CUB SCOUT PERSONAL HEALTH & MEDICAL RECORD

PLEASE PRINT ALL OF THE FOLLOWING INFORMATION:

Participant's Name:

Address:

City or Town | State | Zip Code

Phone Number: ( ) - -

Area Code | Number

The above named individual is currently registered with (*Put the Unit Number in the box)*:

Cub Scout Pack ☐ **Boy Scout Troop** ☐ **Explorer Post** ☐

If your child has had a medical examination (physical examination) within the last 36 months, a copy of the results of this examination must be attached to the health history for all participants in a camping experience lasting *longer than 72 consecutive hours*. If a copy is not available, a physical examination (using A Class 2 form) must be scheduled by a *licensed healthcare practitioner. This physical examination is also *required* if your child is currently under medical care, takes a prescribed medication, requires a medically prescribed diet, has had an injury or illness during the past 6 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from a head injury.

*Examinations conducted by licensed healthcare practitioners, other than physicians, will be recognized for BSA purposes in those states where such practitioners may perform physical examinations within their legally prescribed scope of practice.

ALL PARTICIPANTS MUST HAVE A MEDICAL FORM ON-FILE AT THE TIME OF THE EVENT!

FORMS WILL BE RETURNED TO THE UNIT AT CHECKOUT.

CLASS 1 MEDICAL INFORMATION – Past or Present: (Please check appropriate boxes & explain)

Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No

Explanations or other conditions _____

Allergies:	Food	☐ Yes	☐ No	Plants	☐ Yes	☐ No
	Medicines	☐ Yes	☐ No	Insect Bites	☐ Yes	☐ No

Explanations _____

Any reason to restrict full activity including swimming, long hikes, backpacking, strenuous physical games? ☐ Yes ☐ No List BELOW.

List any conditions limiting full participation (Physical or emotional) _____

Any reason for medicines to be taken at camp? ☐ Yes ☐ No List medicines BELOW & send ample supplies and directions for use.

Any special equipment such as orthopedic or handicap devices, glasses or contacts, dentures? ☐ Yes ☐ No Explain BELOW.

Explain any "Yes" answers and give all information needed to provide as safe and as full participation as possible. _____

_____

_____

Immunizations:	Date of last inoculation		Date of last inoculation		Date of last inoculation
Tetanus Toxoid	_____	Polio	_____	Mumps	_____
Diphtheria	_____	Pertussis	_____	Measles	_____
Rubella	_____				

Name of personal physician _____ Telephone _____

Personal Health/Accident Insurance Carrier _____ Policy No. _____

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission for a physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections or medication for my child.

Date: _____ Signature of parent or guardian _____